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ABSTRACT

The report aims to describe chronic drug users, emerging drugs, new routes of administration, varying use patterns, changing demand for treatment, drug-related criminal activity, drug markets, and shifts in supply and distribution patterns. Pulse Check regularly addresses four drugs of serious concern: heroin, crack cocaine/powder cocaine, marijuana, and methamphetamine. Additionally, due to their spread across the country, it continues to monitor the problems of "ecstasy," the diversion and abuse of OxyContin, and other drugs of concern. This report is based on discussions with 78 epidemiologists, ethnographers, law enforcement officials, and methadone and non-methadone treatment providers from 20 Pulse Check sites. Telephone discussions with these individuals, conducted between late June and early August 2002, reveal that overall, when comparing spring 2002 with the previous fall period, the majority of "Pulse Check" sources believe their communities' drug abuse problem to be very serious but stable, although a substantial percentage believe the situation to be somewhat worse. Five appendixes present the research methodology, population demographics, national level data sources, Pulse Check sources, and discussion areas by source type. (GCP)

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Special Topic:
A Look At Local Drug Markets

PULSE CHECK

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Trends in Drug Abuse

January–June 2002 Reporting Period

Executive Office of the President
Office of National Drug Control Policy
November 2002

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PULSE CHECK

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Washington, DC 20503
NCJ 197242

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This issue and previous issues of *Pulse Check* are available online at <www.whitehousedrugpolicy.gov>.

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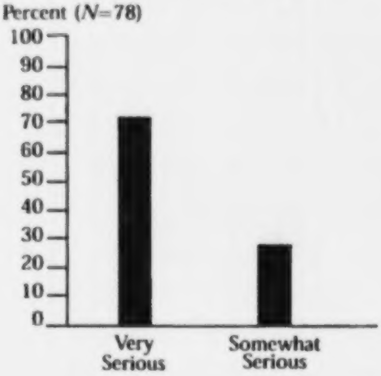
PULSE CHECK HIGHLIGHTS+

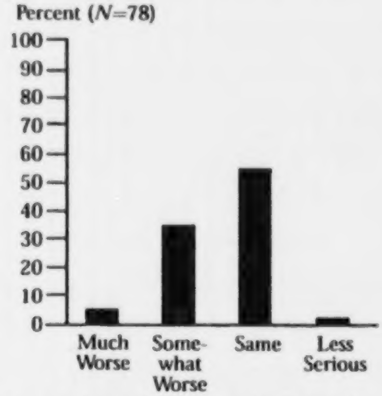
This report is based on discussions with 78 epidemiologists, ethnographers, law enforcement officials, and methadone and non-methadone treatment providers from 20 *Pulse Check* sites. Telephone discussions with these individuals, conducted between late June and early August 2002, reveal that overall, when comparing spring 2002 with the previous fall period, the majority of *Pulse Check* sources believe their communities' drug abuse problem to be very serious but stable, although a substantial percentage believe the situation to be somewhat worse. *(Exhibits 1 and 2)*

Exhibit 1.
How serious is the perceived drug problem in the 20 Pulse Check communities (spring 2002)?



Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

Exhibit 2.
How has the perceived drug problem changed (fall 2001 vs spring 2002)?



Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

The illicit drug situation is characterized by several key features:

- Heroin continues to surpass crack as the drug associated with the most serious consequences, as perceived by 31 sources in 15 cities, particularly in the Northeast and Midwest. *(Exhibits 3 and 4)*
- Crack remains a serious problem, according to 21 sources in 14 cities, particularly in the South. One source in Memphis suggests that crack has overtaken marijuana as the most commonly abused drug. *(Exhibits 3, 4, and 5)*
- Marijuana remains the most widely abused illicit drug, as reported by 34 sources in 17 cities. *(Exhibits 3 and 4)*
- Methamphetamine is reported as an emerging or intensifying problem in 10 cities. *(Exhibit 6)* Furthermore, sources in eight cities, particularly in the West, consider it the drug contributing to the most serious consequences. *(Exhibits 3 and 4)*
- Some signs indicate that diversion of OxyContin® (oxycodone hydrochloride controlled-released) might have peaked during the last reporting period. However, it continues to be reported as an emerging problem by sources in 14 *Pulse Check* cities. *(Exhibit 6)*
- Ecstasy (methylenedioxymethamphetamine or MDMA) continues to emerge or intensify as a problem in all but five *Pulse Check* cities: in Detroit, Miami, New Orleans, New York, and Portland (ME), it has now either leveled off or has become an established drug of abuse. *(Exhibit 6)*

HIGHLIGHTS FROM THE SPECIAL TOPIC SECTION: A LOOK AT LOCAL DRUG MARKETS

- Marijuana is the illicit drug most easily purchased by both users and undercover police, followed by crack.
- Users find it a bit more difficult than undercover police to purchase powder cocaine.
- Heroin is also relatively easy to purchase on the street. Undercover police generally find it slightly more difficult to purchase than crack or powder cocaine. Users, on average, purchase heroin with more difficulty than crack but with less difficulty than powder cocaine.

+The following symbols appear throughout these Highlights to indicate type of respondent: 'Law enforcement respondent, 'Epidemiologic/ethnographic respondent, "Non-methadone treatment respondent, and "Methadone treatment respondent.

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- Of the five drugs discussed, methamphetamine is the most difficult to purchase overall. It is easiest to purchase the drug in Honolulu, Los Angeles, Memphis, and Sioux Falls.
- Only a few sources report that users or undercover police had a hard time buying drugs at any specific times during this reporting period.
- Drug markets in several *Pulse Check* cities appear more active when users receive paychecks or Government checks, on or before weekends and holidays, when police presence is low, and when supply is up.
- Beepers and cell phones are the most common means of communication between dealers and their buyers, suppliers, and fellow dealers.
- Motor vehicles, usually personal cars, are the most frequently mentioned means of moving drugs.
- Dealers generally accept mostly cash in payment for drugs. They do, however, occasionally accept other modes of payment, such as sex, property or merchandise, other drugs, drug transport, and other items or services.
- Dealers dispose of cash from drug sales in many ways, including money laundering in various forms, "re-upping" supplies, spending on entertainment, and passing money up the supply ladder.
- An intense and visible police presence is, by far, the most effective, albeit short-term, deterrent to street drug buys.

Exhibit 3. What are the most serious drug problems in the 20 *Pulse Check* cities, by type of source?

	Drug	Most commonly abused?*			Most serious consequences?			
		L	E	N	L	E	N	M
Northeast	Boston, MA	MJ	MJ	H	HCl	Crack	H	H
	New York, NY	MJ	MJ	Crack	H	Crack	Crack	Crack
	Philadelphia, PA	MJ	MJ	H	H	H	Crack	H
	Portland, ME	H	MJ	H	H	H	H	H
South	Baltimore, MD	MJ	H	H	Crack	H	H	Benzos
	Columbia, SC	Crack	MJ	MJ	Crack	Crack	MJ	H
	El Paso, TX	MJ	MJ	Cocaine	H	Crack	H	Cocaine
	Memphis, TN	Meth	Crack	Crack	Meth	Crack	Crack	Benzos
	Miami, FL	Crack	MJ	Crack	Oxy	HCl + Crack	Crack	Benzos
	New Orleans, LA	Crack	H	Crack	H	Crack	Crack	NR
	Washington, DC	MJ	MJ	Crack	Crack	H	H	H
Midwest	Chicago, IL	Crack	MJ	MJ	Crack	H	H	H
	Detroit, MI	MJ	MJ	Crack	H	H	Crack	H
	Sioux Falls, SD	MJ	MJ	MJ	Meth	Meth	MJ	NR
	St. Louis, MO	MJ	MJ	MJ	Crack	Crack	Meth	H
West	Billings, MT	Meth	MJ	MJ	Meth	Meth	Meth	Meth
	Denver, CO	MJ	MJ	Meth	Meth	HCl	Meth	H
	Honolulu, HI	Meth	Meth	Meth	Meth	Meth	Meth	Benzos
	Los Angeles, CA	Crack	MJ	MJ	Crack	H	Meth	H
	Seattle, WA	MJ	MJ	MJ	Meth	H	MJ	H

**Methadone treatment sources are excluded from this count.*
Sources: Law enforcement, epidemiologic/ethnographic, non-methodone treatment, and methadone treatment respondents
NR = Not reported

Exhibit 4. What are the most serious drug problems in the 20 *Pulse Check* cities, by number of sources and sites?

	Most commonly abused?*		Most serious consequences?	
Drug	No. of sources	No. of sites	No. of sources	No. of sites
Heroin	7	5	31	15
Crack	12	9	21	14
Powder cocaine	1	1	3	3
Marijuana	34	17	3	3
Methamphetamine	6	4	15	8
Diverted OxyContin®	0	0	1	1
Benzodiazepines	0	0	4	4

**Methadone treatment sources are excluded from this count.*
Sources: Law enforcement, epidemiologic/ethnographic, non-methodone treatment, and methadone treatment respondents

Exhibit 5. How has the perceived drug problem changed (fall 2001 vs spring 2002)?

Where has "the most commonly abused drug" changed?

City/Source	Fall 2001	Spring 2002
Memphis, TN[E]	Marijuana	Crack
El Paso, TX[M]	Cocaine	Heroin
Honolulu, HI[L]	Marijuana	Methamphetamine
New Orleans, LA[E]	Crack	Heroin
Portland, ME[L]	Marijuana	Heroin
Washington, DC[M]	Heroin	Benzodiazepines
Washington, DC[L]	Crack	Marijuana

Where has the drug with "the most serious consequences" changed?

City/Source	Fall 2001	Spring 2002
Denver, CO[L]	Powder cocaine	Methamphetamine
Honolulu, HI[M]	Heroin	Benzodiazepines
Memphis, TN[L]	Marijuana	Methamphetamine
Miami, FL[E]	Heroin	Cocaine + narcotics
Portland, ME[L,E]	Pharmaceutical opiates	Heroin
Seattle, WA[N]	Cocaine	Marijuana
Washington, DC[N]	Crack	Heroin

HIGHLIGHTS OF TREATMENT ISSUES

Epidemiologic/ethnographic and treatment sources discuss various treatment issues, such as methadone maintenance capacity, treatment referral sources, adverse health consequences, barriers to treatment, and diagnoses of psychiatric comorbidity:

- Since the last *Pulse Check*, public methadone maintenance capacity has decreased somewhat in Chicago. Private capacity, however, has increased in Memphis, Miami, New Orleans, and Portland (ME), although waiting lists are reported by six sources.
- Drug users, particularly those who use marijuana or crack, are predominantly referred to treatment through courts or the criminal justice system. Referral sources have remained generally stable since the last reporting period.
- The impact of drug use on AIDS and HIV seems to have stabilized in the majority of treatment programs. Reported hepatitis C cases, however, continue to increase, usually because of increased screening and awareness.
- The most reported barriers to drug treatment (in descending order) are limited slot capacity, lack of trained staff to treat comorbid mental health disorders, and violent behavior among presenting clients.
- Mood and conduct disorders are the most commonly reported mental health diagnoses among drug treatment clients, according to treatment respondents.

HIGHLIGHTS BY SPECIFIC ILLICIT DRUG

The 78 discussions also yielded key findings about heroin, crack, powder cocaine, marijuana, methamphetamine, synthetic opioids, ecstasy, and GHB (gamma hydroxybutyrate).

HEROIN

- Heroin availability remains generally stable. Only six increases are reported (in Boston[E], Columbia [SC][E], Denver[L], Memphis[L], Miami[E], and Portland [ME][L,E]) and one decline (in Philadelphia[L]). High-purity snortable South American (Colombian) white heroin remains the most common variety, especially in the Northeast.
- Sources report declining prices, especially for larger quantities of heroin, in six cities in the Northeast and West.
- Brand names still proliferate in the Northeast and South, but they are becoming less common in several cities, such as Boston and Philadelphia. Possibly, dealers fear that labels and brand names make them vulnerable to law enforcement.
- Local drug market structures vary from city to city, but they are generally stable, with a few exceptions. For example, sales in Boston continue to decentralize, as users increasingly support their habits by selling heroin; by contrast, in nearby Portland, independent locals are increasingly working together.
- A younger cohort of heroin users is reported in Boston, Miami, New Orleans, Portland, St. Louis, Seattle, and Washington, DC. By contrast, aging heroin-using populations are reported in El Paso, Philadelphia, and St. Louis.
- Users of diverted OxyContin® in Portland are switching to heroin, which is now easier to obtain.
- The number of heroin clients has increased in non-methadone programs in nine *Pulse Check* cities.
- Snorting has increased in seven nonwestern cities. Injecting, however, has reportedly increased in Boston[E] and Portland[E,N], resulting in new hepatitis C cases among young adults.

Exhibit 6. What new problems have emerged or intensified during spring 2002?

Ecstasy/Club Drugs	OxyContin®	Methamphetamine	Other Emerging Drug Problems
Baltimore, MD^{M}	Baltimore, MD^{L}	Columbia, SC^{L}	**Benzodiazepines**: Boston, MA^{E}
Billings, MT^{N}	Billings, MT^{N}	Denver, CO^{E}	**Clonidine (Catapres®)**: Baltimore, MD^{M}
Boston, MA^{L}	Boston, MA^{L,E,M,N}	Detroit, MI^{E}	**Cocaine**: Portland, ME^{M}
Chicago, IL^{L}	Columbia, SC^{E,N}	El Paso, TX^{N}	**Diverted methadone**: Portland, ME^{L,E,N}
Columbia, SC^{L}	Denver, CO^{M}	Memphis, TN^{E}	**DXM (dextromethorphan)**: Denver,CO^{E}
Denver, CO^{L,E}	El Paso, TX^{M}	Miami, FL^{E}	**GHB**: Denver, CO^{E}; Los Angeles, CA^{E}
El Paso, TX^{E}	Honolulu, HI^{E,M,N}	New York, NY^{L}	**Ketamine**: Denver, CO^{E}; El Paso, TX^{E};
Honolulu, HI^{N}	Memphis, TN^{E}	St. Louis, MO^{L,E}	New Orleans, LA^{L}; Sioux Falls, SD^{L}
Los Angeles, CA^{L,E,N}	New Orleans, LA^{L,E}	Seattle, WA^{L,N}	**Khat***: Boston, MA^{L}
Memphis, TN^{N}	New York, NY^{M}	Sioux Falls, SD^{E}	**Other opiates**: Billings, MT^{N}
Philadelphia, PA^{E,M}	Philadelphia, PA^{E,M,N}		Boston, MA^{E}
St. Louis, MO^{E}	St. Louis, MO^{N}		Columbia, SC^{E}
Seattle, WA^{L}	Seattle, WA^{L,E,M,N}		Denver, CO^{E}
Sioux Falls, SD^{L}	Washington, DC^{E}		**PCP**: Philadelphia, PA^{E}
Washington, DC^{L}			Washington, DC^{M}
			Powder Cocaine: Sioux Falls, SD^{E,N}

**Khat is a natural stimulant from the Catha Edulis plant, found in a flowering evergreen tree or large shrub from East Africa and Southern Arabia. Its leaves contain psychoactive ingredients structurally and chemically similar to d-amphetamine.*

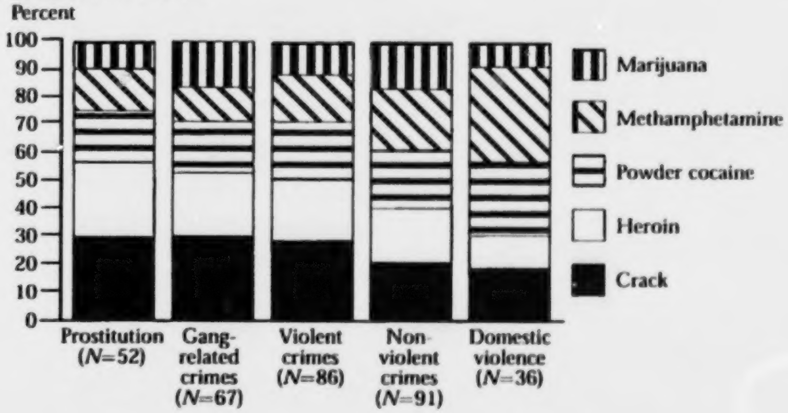
CRACK COCAINE

- Availability remains generally wide and stable. Declines are perceived in four cities (Boston^{L,E}, Honolulu^{E}, Philadelphia^{L}, and Seattle^{E}), and increases are perceived in another four (Billings^{L}, Memphis^{E}, New York^{E}, and Sioux Falls^{L}).
- Crack tends to be processed locally (from powder cocaine), either by local distributors or users, because Federal guidelines for distributing crack are stricter than for powder.
- Overall, street-level crack sellers are equally likely to operate independently than as part of organized sales structures—unlike sellers of other illicit drugs, who are more likely to operate independently.
- Only a few changes are reported in market techniques and locations. For example, in Boston, sales continue to be more "underground" than before, with more beeper and cell phone use. In Philadelphia, sales are similarly moving indoors, while outdoor markets are constantly relocating to evade law enforcement.
- Crack sales are associated with prostitution, gang-related crime, and violent crime more often than other drug sales. *(Exhibit 7)*
- Crack users tend to be predominantly young adults (18–30 years), but adolescent users are increasing in Billings, Los Angeles, and Sioux Falls.

POWDER COCAINE

- Availability remains generally wide and stable, with declines in two cities (Honolulu^{E} and Philadelphia^{L}) and increases in four (Memphis^{L}, New York^{E}, Portland [ME]^{L}, and Sioux Falls^{E}).
- Powder cocaine sellers are predominantly young adults (18–30 years), but adolescents also sell the drug in Chicago^{E} and Los Angeles^{L,E}.
- Powder cocaine sellers are more likely to use their own drug than heroin or crack sellers *(Exhibit 8)*.
- Unlike heroin and crack markets, which are located primarily in central city areas, powder cocaine markets are more evenly distributed among geographic areas.
- Indoor and outdoor sales are equally common in the majority of cities. Frequent settings include nightclubs, bars, raves, and concerts.
- In Portland, sellers are increasingly organized and are selling greater quantities of powder cocaine. Elsewhere, the market appears relatively stable.
- The number of powder cocaine users in treatment increased according to seven sources (in Chicago^{N}, Columbia [SC]^{N}, Denver^{E}, Hono-lulu^{N}, Miami^{E}, and Sioux Falls^{E,N}) and declined according to four (in Columbia^{E}, Denver^{N,M}, and Portland^{N}).

Exhibit 7.
In what crimes, besides drug sales, are illicit drug sellers involved across *Pulse Check* cities?



Sources: Law enforcement and epidemiologic/ethnographic respondents

- Preadolescent and adolescent powder cocaine users in the Sioux Falls[N] program have increased since the last reporting period.
- Injecting has increased in El Paso and Sioux Falls. It is a common route of administration when powder cocaine is used in combination with heroin. Snorting, however, remains the predominant route of administration across sites.

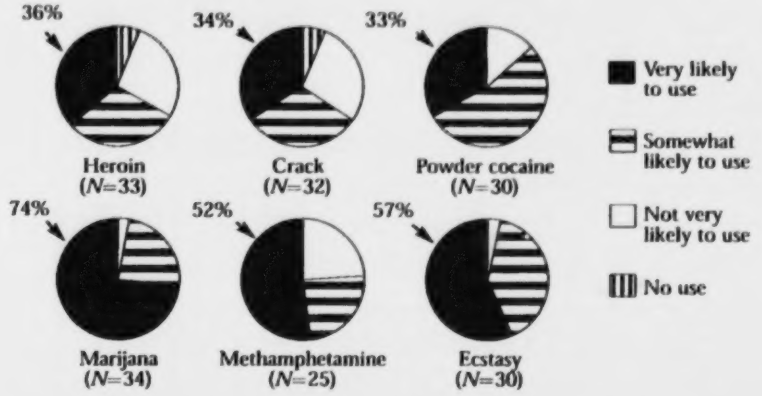
MARIJUANA

- Honolulu, Memphis, and New Orleans are the only three cities where no *Pulse Check* source names marijuana as their community's most widely abused drug.
- Non-methadone treatment sources in Columbia (SC), Seattle, and Sioux Falls consider marijuana the drug that contributes to the most serious consequences.
- Availability remains wide and generally stable. A few increases are reported in availability of indoor-grown hydroponic marijuana. British Columbian marijuana ("BC bud") availability has increased in five cities, mostly in the West.
- Marijuana wraps, often sold in several colors and flavors, are becoming increasingly common, as reported in El Paso, Miami, Philadelphia, and Washington, DC. Sometimes, as in El Paso, they are specifically marketed toward young girls.
- Marijuana sellers are very likely to use their own drug, much more so than sellers of other drugs. *(Exhibit 8)*
- Marijuana users are more likely to reside in all locations (central city, suburban, and rural areas) than users of other drugs.
- The age of marijuana users has been declining in several cities, including Boston, Columbia, Honolulu, Los Angeles, Memphis, and Sioux Falls.
- More than half of responding epidemiologic/ethnographic and treatment sources name arrests as an adverse consequence of marijuana use. More than one-third name poor academic performance, deteriorating family or social relationships, poor workplace performance, school absenteeism or truancy, and short-term memory loss (in descending order of frequency).

METHAMPHETAMINE

- Methamphetamine has replaced powder cocaine as the drug contributing to the most serious drug consequences in Denver[L]. It has replaced marijuana as such in Memphis[E].
- The majority of sources report stable availability, but sources in 12 cities believe availability has increased since the last reporting period.
- The number of small, local methamphetamine labs has increased in nine *Pulse Check* cities: Boston, Chicago, Denver, Detroit, Los Angeles, Miami, Portland (ME), St. Louis, and Sioux Falls. Nevertheless, availability levels remain low in many of these cities.
- Methamphetamine sellers are more likely to be involved in domestic violence than sellers of other drugs, according to law enforcement and epidemiologic/ethnographic respondents. *(Exhibit 7)*
- Methamphetamine markets and use have been spreading within communities: sometimes from the city toward rural areas, as in Denver, Memphis, Seattle, and Sioux Falls; sometimes from rural toward city areas, as in Chicago, Los Angeles, Miami, parts of New York, and St. Louis.

Exhibit 8.
How likely are sellers to use their own drugs across Pulse Check cities, by drug?



Sources: Law enforcement and epidemiologic/ethnographic respondents

DIVERTED SYNTHETIC OPIOIDS

- Availability of diverted OxyContin® has remained stable according to half of the *Pulse Check* sources, particularly in the Midwest. Increases, however, are still reported in 10 cities, while declines are reported in 4.
- In Philadelphia and Portland (ME), declines in some aspects of the diverted OxyContin® problem are attributed to a combination of legislation, arrests, education, press coverage, and changed prescription policies.
- Despite declining or stabilizing availability, adverse consequences are still increasing in Philadelphia (in mortality and emergency department episodes) and Portland (in people initiating use).
- In Boston, pharmacy robberies involving OxyContin® continue to increase, and sales of the diverted drug appear more organized than in the past.
- Diverted OxyContin® is sold by a wide range of individuals, mostly independent—from elderly "pill ladies" in Columbia (SC) to "bad" doctors and pharmacists in Seattle to addicts as well as armed criminals in Boston.
- Since the last reporting period, among treatment programs where abuse of diverted OxyContin® is reported, the number of users has increased substantially in 3, increased somewhat in 16, and remained stable in 10 *Pulse Check* cites.
- Abusers of OxyContin® reside predominantly in central city areas according to sources in half of the *Pulse Check* cities, dispelling the myth of "hillbilly heroin."

ECSTASY (methylenedioxymethamphetamine or MDMA)

- About half of the respondents report that ecstasy availability has increased. Approximately half report that it has remained stable, often at elevated levels.
- Fewer sources report adulterated ecstasy than in the last *Pulse Check*. However, fraudulent substitutions (such as hormone replacement pills) have been confiscated in some cities (such as Detroit, St. Louis, and Seattle).
- Nearly all respondents believe that sellers are very likely or somewhat likely to use their own ecstasy. *(Exhibit 8)*
- The ecstasy market continues to move to the street—beyond the rave, concert, and club scene—unlike markets for drugs like heroin and cocaine, which are increasingly moving indoors in some cities.
- Younger students are using ecstasy in some cities (such as Baltimore and Boston).
- While users tend to be middle socioeconomic Whites, increasing use is reported among some minorities and lower socioeconomic groups (in Memphis, New York, St. Louis, and Sioux Falls).

GHB (gamma hydroxybutyrate)

- GHB is mentioned as an emerging problem in Denver and Los Angeles.
- Wide availability is reported in Denver, Los Angeles, Miami, and New Orleans. Availability has increased in Los Angeles[L,E], Memphis[L], and Sioux Falls[L]. It has declined in Miami[E] and St. Louis[L,E].

KETAMINE ("Special K")

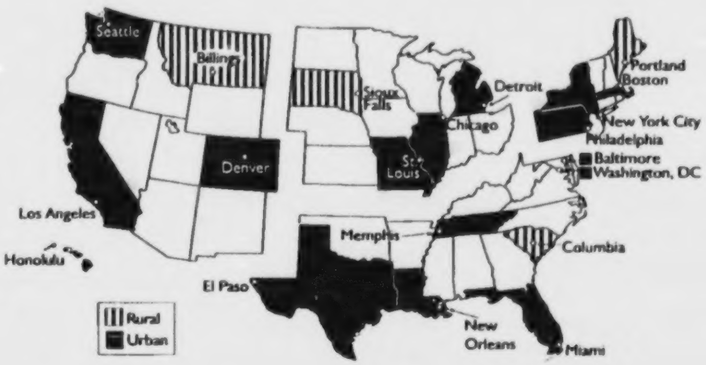
- Ketamine is reported as an emerging or intensifying drug problem in Denver, El Paso, New Orleans, and Sioux Falls. It is increasingly available in Memphis.
- The drug is sometimes associated with the club or rave scene.

INTRODUCTION

Since 1992, the Office of National Drug Control Policy (ONDCP) has published the *Pulse Check*, a source for timely information on drug abuse and drug markets. The report aims to describe chronic drug users, emerging drugs, new routes of administration, varying use patterns, changing demand for treatment, drug-related criminal activity, drug markets, and shifts in supply and distribution patterns. *Pulse Check* regularly addresses four drugs of serious concern: heroin, crack cocaine/powder cocaine, marijuana, and methamphetamine. Additionally, due to their spread across the country, *Pulse Check* continues to monitor the problems of "ecstasy" (methylenedioxymethamphetamine or MDMA), the diversion and abuse of OxyContin® (a controlled-release formulation of the pharmaceutical opiate oxycodone), and other drugs of concern.

The *Pulse Check* is not designed to be used as a law enforcement tool but rather to be a research report presenting findings on drug use patterns and drug markets as reported by ethnographers, epidemiologists, treatment providers, and law enforcement officials. With regards to race and ethnicity, just as the National Household Survey on Drug Abuse and other national data sources report findings by race and ethnicity, sources contributing to the *Pulse Check* are asked to describe the age, ethnicity, and gender of illegal drug users and those who sell drugs and any changes in these characteristics. The information provided to *Pulse Check* reflects the observations of the sources, and their descriptions are purely for determining the size, scope, and diversity of the drug problem. The intent of the *Pulse Check* has been and continues to be merely to describe patterns in illicit drug use and illicit drug markets that are emerging in local communities.

The 20 Pulse Check Sites



Use and Interpretation of Pulse Check Information

By contacting professionals from three different disciplines—ethnography/epidemiology, law enforcement, and treatment—a rich picture of the changing drug abuse situation emerges. Though this approach offers substantial strengths in timeliness and depth, *Pulse Check* is not intended as a quantitative measure of the prevalence of drug abuse or its consequences. Any interpretation or conclusion drawn from *Pulse Check* must be viewed carefully and in conjunction with other more quantifiable direct and indirect measures of the drug abuse problem. More specifically, several of the limitations of *Pulse Check* are briefly discussed below.

Pulse Check focuses on the drug abuse situation in 20 specific sites throughout the Nation. Though considerable effort was made to select sites across a broad range of geographic areas, including Census regions and divisions, urban and rural States, racial/ethnic coverage, and High Intensity Drug Trafficking Areas, *Pulse Check* cannot be viewed as a national study, and information cannot be reasonably aggregated up to a national level.

Of the 80 sources identified and recruited across the three disciplines, 78 provided information for this *Pulse Check* issue.

The information presented in this report is based solely on the observations and perceptions of those 78 individuals. These individuals may not be knowledgeable about every aspect of the drug abuse situation in their sites, and they may have biases based on their experiences and exposures.

Due to the comprehensive nature of the telephone discussions, sources were asked to discuss only areas in which they were thoroughly knowledgeable. Thus, the total number (*N*) of respondents to any one question might be less than 78.

Any contradictory reports within an individual site are not necessarily a

Pulse Check limitation. Just as the site sampling methodology was designed to reflect the country's geographic and population diversity, recruiting four sources per site was incorporated into the design to reflect diversity within each site. For example, a law enforcement source in one site might perceive cocaine to be the community's most serious problem, while an ethnographic source at that same site might consider the most serious problem to be heroin. And they would both be right—because each might come in contact with different populations or each might deal with a specific geographic neighborhood.

Information from treatment sources is particularly susceptible to variance because some facilities target specific populations. Furthermore, treatment providers from methadone and non-methadone programs are likely to have very different perspectives on their communities' drug problems because their respective clientele differ in the nature of their drug problems and in their demographic characteristics. It is for this reason that two treatment sources were selected from each of the 20 sites—one from a methadone program, and one from a non-methadone program. Taken together, all four sources at each site provide a richer picture of the drug problem's nature.

Current Sources and Reporting Periods

The current report includes information gathered during June 17 through August 5, 2002, from telephone conversations with 78 sources, representing 20 sites across the various regions of the country. These individuals discussed their perceptions of the drug abuse situation as it was during the spring months of 2002 and in comparison to a period 6 months earlier, during fall 2001.

The law enforcement sources who provided information include 20 narcotics officers from local police departments, field office agents of the Drug Enforcement Administration (DEA), and representatives of High Intensity Drug Trafficking Areas (HIDTAs).

The epidemiologists and ethnographers are 20 researchers associated either with local health departments, university-based research groups, or other community health organizations. Some of those 20 individuals are qualitative researchers who employ ethnographic techniques to obtain observational data directly from the drug user's world; others are epidemiologists who access both qualitative and quantitative data.

The treatment sources are 38 providers from 21 non-methadone programs and 17 methadone programs across the 20 sites. Those providers include two non-methadone sources each from Billings because that city does not have a methadone program. They do not include another two individuals who were unable to participate in this round of discussions: the methadone treatment source from New Orleans; and one of the two non-methadone treatment sources from Sioux Falls (where, as in Billings, there are no methadone programs).

These sources offer a wealth of information that, when taken together, provides a comprehensive snapshot of drug abuse patterns in communities across the country. Further, these individuals provide expertise that can alert policymakers to any short-term changes or newly emerging problems concerning specific drugs, drug users, and drug sellers.

The appendices at the end of this report provide a list of these sources, describe the methodology used to select them, and discuss the content of the approximately 1-hour conversations held with them.

A LOOK AT LOCAL DRUG MARKETS[*]

Local drug markets, like any economic markets, are subject to a wide variety of influences. Thus, in order to disrupt street-level drug markets within local communities, it is necessary to understand how they operate.

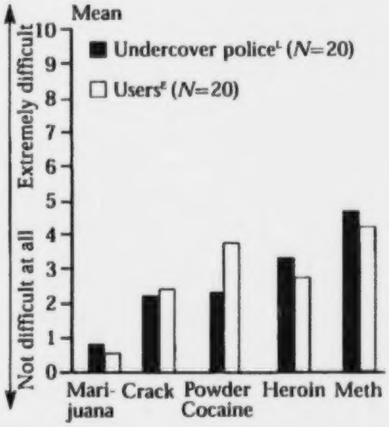
As key informants and opinion leaders in their communities, *Pulse Check* sources are well positioned to describe drug market activity, pinpoint its vulnerabilities, and suggest ways to disrupt it. Therefore, during our routine semiannual telephone discussions conducted June 17 through August 5, 2002, we asked *Pulse Check*'s 20 law enforcement and 20 epidemiologic/ethnographic sources a series of market-related questions relevant to their specific areas of expertise.

Questions included the following: How difficult is it to buy drugs? When do local drug markets seem most active? When do they slow down? How do street-level dealers communicate with each other, with their suppliers, and with their buyers? How do dealers transport drugs to their selling locations? What else, besides cash, do dealers accept in exchange for drugs? What happens to cash collected by street dealers? What deters street drug buys? How do targeted law enforcement or legislative policy directives impact communities' drug problems? How can local drug market activity be disrupted? What challenges face law enforcement efforts?

In responding, the law enforcement sources provided information and opinions from the undercover police officer's point of view, while the epidemiologic/ethnographic sources described market activity from the user's perspective.

How difficult is it to buy drugs? *(Exhibits 1–4)* Marijuana is the most easily purchased illicit drug, both for undercover police and users: on average, on a 0–10 scale (with 0 being "not difficult at all" and 10 being "extremely difficult"), the 40 law enforcement and epidemiologic/ethnographic sources rate it at less than 1. Specifically, undercover police find it not difficult at all to purchase marijuana in 9 sites and fairly easy to purchase in another 10 sites. Only in Philadelphia, where police do not make undercover marijuana buys, does the law enforcement source report, anecdotally, that it is moderately difficult to purchase marijuana.

Exhibit 1.
How difficult is it for undercover police and users to buy drugs? (Averages, 0–10 scale)



Source: Law enforcement (L) and epidemiologic/ethnographic (E) respondents

Similarly, according to epidemiologic/ethnographic sources, users find it not difficult at all to purchase marijuana in half of the sites and fairly easy to do so in the other half.

Crack is the second most easily purchased illicit drug at the street level. According to undercover police, it is easily obtained in Columbia (SC), Denver, Los Angeles, New York, St. Louis, and Washington, DC. Users can obtain crack easily in Baltimore, Memphis, New Orleans, New York, Philadelphia, and Washington, DC. At the other extreme, it is most difficult to purchase crack in Billings (for users) and Sioux Falls (for undercover police).

Powder cocaine is easily purchased by undercover police in the same six sites as crack. By contrast, it is relatively difficult to purchase street-level powder cocaine in Philadelphia and Detroit. Users find it a bit more difficult than undercover police to purchase powder cocaine, particularly in Billings and Washington, DC.

Heroin is also relatively easy to purchase on the street, but slightly more difficult than crack or powder cocaine, according to law enforcement sources. Undercover purchases are not difficult at all in five sites, while, by contrast, it is difficult to purchase heroin undercover in Billings and Philadelphia and extremely difficult in Sioux Falls. The difficulty in purchasing drugs in Philadelphia results from that city's recent Operation Safe Streets, which has disrupted the more than 200 open-air drug markets. Users, on average, purchase heroin with more difficulty than crack, but with less difficulty than powder cocaine.

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[*] The following symbols appear throughout this chapter to indicate type of respondent: [L] Law enforcement respondent, [E] Epidemiologic/ethnographic respondent, [N] Non-methadone treatment respondent, and [M] Methadone treatment respondent.

Exhibit 2.
How difficult is it for undercover police (UP) and users (U) to buy specific drugs across the 20 *Pulse Check* cities?*

City		Heroin		Crack		Powder cocaine		Marijuana		Meth	
		UP^{L}	U^{E}	UP^{L}	U^{E}	UP^{L}	U^{E}	UP^{L}	U^{E}	UP^{L}	U^{E}
Northeast	Boston, MA	1	3	2	2	1	3	2	1	4	10
	New York, NY	0	0	0	0	0	1	0	0	5	9
	Philadelphia, PA	0/9**	1	0/6**	0	0/7**	7	4.5	1	7	9
	Portland, ME	6	3	5	7	4	7	1	1	9	7
South	Baltimore, MD	4	0	2	0	2	0	1	0	8	NR
	Columbia, SC	4	7	0	4	0	4	0	2	8	6
	El Paso, TX	2	2	4	1	2	1	2	1	4	3
	Memphis, TN	2	3	1	0	1	1	1	0	1	0
	Miami, FL	1	2	1	1	1	0	1	0	9	5
	New Orleans, LA	7	0	2	0	2	3	1	0	8	7
	Washington, DC	0	0	0	0	0	10	0	0	5	NR
Midwest	Chicago, IL	1	1	1	1	3	3	1	1	10	9
	Detroit, MI	2	5	1	2	8	3	0	2	6	5
	Sioux Falls, SD	10	8	9	8	5	7	2	0	2	0
	St. Louis, MO	0	3	0	2	0	4	0	1	3	3
West	Billings, MT	9	10	5	10	4	10	0	1	0	3
	Denver, CO	0	2	0	4	0	1	0	0	1	2
	Honolulu, HI	4	5	1	4	2	7	0	0	0	2
	Los Angeles, CA	0	2	0	2	0	6	0	0	0	2
	Seattle, WA	4	1	4	1	3	1	2	1	4	1

Source: Law enforcement (L) and epidemiologic/ethnographic (E) respondents
**0–10 scale: 0 = not difficult at all; 10 = extremely difficult*
***In Philadelphia, "0" ratings are wholesale, higher ratings are retail.*

Of the five drugs discussed, methamphetamine is the most difficult to purchase and has the most variability across the 20 sites. Every degree of difficulty (from 0 through 10) is reported. At the two extremes, it is easiest to purchase methamphetamine in Honolulu, Los Angeles, Memphis, and Sioux Falls, and it is most difficult to purchase it in Boston and Chicago.

Is there any particular day, week, or month that local drug markets seem more active?

Four themes emerge in discussions about time-related increases in market activity: personal income, weekends and holidays, police presence, and supply.

- **When personal income goes up:** Law enforcement sources in seven sites—Billings, Columbia (SC), Memphis, New Orleans, Philadelphia, Seattle, and Washington, DC—note that market activity appears to increase at times of the month when people get paychecks or Government checks, usually around the 1st of the month, sometimes also around the 15th. The Memphis source also notes an increase around tax refund time. Similar observations are made by epidemiologic/ethnographic sources in eight sites: Baltimore, Chicago, Columbia, Denver, El Paso, Los Angeles, Memphis, and New Orleans. The El Paso source adds that more people enter detox toward the end of the month to tide them over until more money becomes available at the beginning of the month and they can once again buy their drugs of choice.
- **On or before weekends and holidays:** The Philadelphia law enforcement source notes that markets appear more active on Thursdays, Fridays, and Saturdays; conversely, they are less active on religious holidays. Similarly, in Sioux Falls, markets appear more active on weekends. In Miami too, dealers sell on the street from Thursday through Sunday, noon till midnight. Individual dealers work 8-hour shifts during that time, with "new guys" getting the late night shift. Additionally, wholesale cocaine sales tend to slow down in Miami from late November to late January, as distributors stock up so that their inventory carries them through the holidays. (This pattern, also reported in the last *Pulse Check*, persisted this year, even after September 11.) In Seattle, where heroin and crack are less available in the suburbs than in downtown areas, market activity increases on Fridays, when outsiders come into town for their weekend supply of those two drugs. Powder cocaine, marijuana, and methamphetamine, however, are available in the suburbs.
- Weekend or holiday increases are also noted by epidemiologic/ethnographic sources in several sites. The Columbia, Denver, and St. Louis sources associate increased activity on weekends with recreational drug use; the St. Louis and Los Angeles sources associate it with Friday paydays; and the New York source notes that outpatients in treatment take their medications home on weekends. In Washington, DC, heroin dealers do not sell on Sundays, but then they run "specials" on

Monday, when users crave the drug. The Detroit source notes increased drug use during election times, possibly because some users are in a celebratory mode. In Philadelphia, by contrast, it is more difficult to get drugs, especially marijuana, on election and primary days, and 2 days beforehand, because of increased police presence.

- **When police presence is low**: The New York law enforcement source notes that market activity increases when police presence is low, as was the case after September 11. Conversely, the Baltimore ethnographic source notes that people avoid buying on the street on known law enforcement "target days."
- **When supply is up**: In Billings, markets are more active when sellers get their drug shipments.

During this reporting period, has there been a time when users could not buy specific drugs? Only a handful of sources report that users had a hard time buying drugs at any specific time:

- **Boston, MA**[E]: The heroin supply temporarily dried up in early winter, around January. Some users speculated about possible relationship with the September 11 attacks. This slight drought, however, was followed by an increase in demand and an upsurge in the sale of weighed gram-sized rocks of heroin.
- **Columbia, SC**[L]: Methamphetamine was temporarily unavailable following the arrest of a clubgoing seller. By the following weekend, a new dealer had taken over.
- **Denver, CO**[L]: Following any big bust, sellers tend to go underground briefly.
- **Miami, FL**[L]: While no slowdown is reported during this period, wholesale drug sales in Miami generally slow down during the holiday season from late November through late January. Dealers fill up their inventories before the holidays, then sell from their inventories. Supply is also disrupted whenever a hurricane hits.
- **St. Louis, MO**[E]: A few recent seizures of "mom-and-pop" methamphetamine labs made it more difficult for small circles of buyers to get the drug. Methamphetamine is still relatively new within that city, as opposed to the surrounding rural areas where it is more established, so any arrest or seizure creates a lull until new contacts are made or new labs are set up.

Exhibit 3.
How difficult is it to buy heroin?

Undercover police[L]	Not difficult at all	Users[E]
Denver, Los Angeles, New York, Philadelphia (wholesale), St. Louis, Washington, DC	0	Baltimore, New Orleans, New York, Washington, DC
Boston, Chicago, Miami	1	Chicago, Philadelphia, Seattle
Detroit, El Paso, Memphis	2	Denver, El Paso, Los Angeles, Miami
	3	Boston, Memphis, Portland (ME), St. Louis
Baltimore, Columbia (SC), Honolulu, Seattle	4	
	5	Detroit, Honolulu
Portland (ME)	6	
New Orleans	7	Columbia (SC)
	8	Sioux Falls
Billings, Philadelphia (retail)	9	
Sioux Falls	10	Billings
	Extremely difficult	

Source: Law enforcement (L) and epidemiologic/ethnographic (E) respondents

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Exhibit 4.
How difficult is it to buy methamphetamine?

Undercover police^{L}	Not difficult at all	Users^{E}
Honolulu, Los Angeles	0	Memphis, Sioux Falls
Memphis, Denver	1	Seattle
Sioux Falls	2	Denver, Honolulu, Los Angeles
St. Louis	3	Billings, El Paso, St. Louis
Boston, El Paso, Seattle	4	
New York, Washington, DC	5	Detroit, Miami
Detroit	6	Columbia (SC)
Philadelphia	7	New Orleans, Portland (ME)
Baltimore, Columbia (SC), New Orleans	8	
Miami, Portland (ME)	9	Chicago, New York, Philadephia
Chicago	10	Boston
	Extremely difficult	

Source: Law enforcement (L) and epidemiologic/ethnographic (E) respondents

- **Philadelphia, PA^{L}**: Law enforcement reports that Operation Safe Streets has made it more difficult for users to obtain drugs.
- **Portland, ME^{L}**: Occasionally, when the source's supply is out, buyers cannot find any crack. These episodes run in streaks.
- **Sioux Falls, SD^{L}**: Crack and powder cocaine are periodically unavailable.

How do street-level dealers communicate? *(Exhibit 5)* Law enforcement sources report beepers and cell phones as the most common means of communication between dealers and their buyers, suppliers, and fellow dealers. Regular telephones (mentioned in seven sites) are less common than cell phones: they are mentioned more often in dealer-to-dealer communications rather than in dealer-supplier or dealer-buyer contexts, and they are sometimes used in rural areas, such as parts of Portland (ME), where cell phones don't always work. Phone cards are used at all market levels in Miami. Some New York dealers use the Internet to communicate with fellow dealers, while Miami dealers use the Internet for both dealer-to-dealer and dealer-to-supplier communications, and Memphis dealers use it to communicate with buyers. Walkie-talkies are used among dealers in Memphis. Hand signals are sometimes used in areas with open street markets, such as Baltimore and Philadelphia. Word of mouth is mentioned in Chicago (dealer-to-buyer), Los Angeles (dealer-to-dealer and dealer-to-buyer), Memphis (dealer-to-dealer and dealer-to-supplier), New Orleans (dealer-to-buyer), and New York (dealer-to-dealer).

Dealers meet face-to-face with other dealers in Chicago, New Orleans, and Washington, DC; with their suppliers in Chicago, Denver, and Memphis; with their buyers in Baltimore, Columbia, Detroit, Honolulu, Memphis, New York, Phildelphia, St. Louis, Seattle, and Washington, DC; and to supplement electronic communication at all levels in Philadelphia. Face-to-face contact between dealers and buyers sometimes occurs at prearranged meetings sites (as in Detroit and Memphis) or at well-known street locations (as in Columbia, New York, and Washington, DC). In New York, suppliers contact dealers, but dealers generally do not contact suppliers.

How do dealers transport drugs to their selling locations? Motor vehicles, usually personal cars, are the most frequently mentioned means of moving drugs, according to the vast majority of law enforcement sources. Other vehicles mentioned include planes (Seattle), rental cars (Portland, ME), taxi cabs (Columbia, SC), motorcycles (Philadelphia), trucks (Memphis, Philadelphia), coach bus (Billings), bikes (Honolulu and Philadelphia), and "trapped vehicles" (vehicles with secret compartments) (Philadelphia). Some dealers carry their drugs on their persons, as in Baltimore, El Paso, Chicago, and Sioux Falls. Foot traffic is mentioned in Chicago, Los Angeles, Philadelphia, and Seattle. Goverment and private shipping and express mail services are mentioned in Memphis. Dealers in some cities, such as Columbia, sometimes use a third party, such as a girl friend who is not actively involved in selling, to transport their drugs.

What else, besides cash, do dealers accept in exchange for drugs? *(Exhibit 6)* Dealers in 16 of the 20 *Pulse Check* cities accept mostly cash in payment for drugs. Occasionally they accept other modes of payment, such as sex, property or merchandise, other drugs, drug transport, and other items or services. Such alternative payment modes are even more common than cash in four cities: Columbia (SC), El Paso, Honolulu, and Memphis.

Sex is sometimes traded for drugs in all 20 sites, and property or merchandise is sometimes accepted as payment in nearly every site. Specified items include fenced goods (in Denver, Philadelphia, and Seattle), stolen property (in Portland [ME] and Los Angeles), jewelry and audio equipment (in Philadelphia), shoplifted merchandise or groceries (in El Paso and Miami), precursor chemicals (in Denver, in exchange for methamphetamine), and vehicles (in Memphis). Guns are mentioned in Baltimore and Philadelphia, and Food Stamps are mentioned in New Orleans and Seattle. In El Paso, users often get their drugs in exchange for bikes, toys, other children's holiday gifts (including those donated by charitable organizations), and even holiday turkeys. In nine cities, mostly in the South and West, specific drugs are sometimes traded for other drugs.

Users in half of the cities sometimes transport other drugs in exchange for their own drugs. For example, "ponying" is common in El Paso, where users act as mules, bringing drugs from Mexico and keeping a portion of the drugs for themselves.

Similarly, in Washington, DC, some users work for their dealer, selling drugs in exchange for their own drugs. In Portland (ME), heroin users support their habits by buying more heroin in nearby Massachusetts areas and then selling it locally. Sometimes users steal their drugs, as reported in seven sites, including Portland, where OxyContin® is sometimes obtained via pharmacy break-ins.

Services are occasionally exchanged for drugs. For example, in Chicago and Detroit, drug "shoppers" get to keep a portion of the drugs they buy for other users. Also in Detroit in exchange for drugs, some people ("hitters") inject other users with hard-to-find veins, and some act as "lookouts."

What happens to the cash collected by street dealers? Law enforcement sources report a wide range of cash-related activities—from sophisticated money laundering operations down to dealers simply "spending it" (as in Billings)—depending on the city and the dealer level.

Money laundering is mentioned in Boston, Memphis, Miami, and

Exhibit 5.
How do dealers and buyers communicate?

Dealers

Face-to-face	Baltimore, Columbia (SC), Detroit, Honolulu, Memphis, New York, Philadelphia, St. Louis, Seattle, Washington, DC
Cell phones/Pagers	Boston, Columbia, Denver, Detroit, El Paso, Los Angeles, Miami, Philadelphia, Seattle
Telephone	Baltimore, Denver, Honolulu, Portland (ME), St. Louis
Word of mouth	Chicago, Los Angeles, New Orleans
Couriers	Philadelphia
Hand signals	Philadelphia
Internet	Memphis
Phone cards	Miami

Buyers

Sources: Law enforcement respondents

Portland (ME). Miami is a particular attraction because it is a tremendous financial center, with many international banks, and because it is a vacation spot where dealers can combine business with pleasure. Several techniques are used in that city: (1) a black market peso exchange—dealers use street drug money to purchase computers, appliances, and other electronics from small businesses around the airport area, then they export the items to Colombia, where a black market shopping center sells them to the public; (2) wire transfers and moneygrams; (3) rental cars used for driving cash to Mexican border areas in Texas or California; (4) off-shore banking; and (5) ATM transactions—cash is deposited at local locations and withdrawn from machines in Colombia.

In Boston, some Dominicans launder money through small storefront businesses. In nearby Portland, one person was recently indicted on 170 counts of laundering money acquired from selling marijuana. Most drug money in that city, however, goes to support the individual sellers' habits or else to "re-up" their supplies acquired on trips to nearby areas, such as Lawrence and Lowell (MA), parts of New Hampshire, and New York City.

As in Portland, street dealers in other cities often use their cash to pay off their suppliers or re-up their supplies, thus perpetuating the cycle. Any leftover cash becomes profit, often used for entertainment, as reported in St. Louis. The Baltimore sellers hold onto the cash for a while until they have an amount substantial enough to take to their suppliers. The Columbia sellers transfer cash to their suppliers (who are located in Texas or California if they supply marijuana) using several techniques: they wire the money; they use air and train travelers; or they send express-mail packages of items filled with cash (such as shoes). Express mail services are also used by higher level dealers in Sioux Falls.

Within many cities, money is passed from one dealer level to the next one up via several techniques. In Philadelphia, for example, cash passes from buyer to "case worker" to "manager" to higher leader via cars, hand-to-hand exchange, bikes, motorcycles, or dropoffs at safe locations. Higher level dealers then use the money to buy real estate, buy

Exhibit 6.
What else, besides cash, is exchanged for drugs?

Regions		Mostly cash	Property/ Merchandise	Sex	Other drugs	Transport drugs	Steal the drug	Other
Northeast	Boston, MA	✓	✓	✓				
	New York, NY	✓	✓	✓	✓	✓	✓	
	Philadelphia, PA	✓	✓	✓				Guns
	Portland, ME	✓	✓	✓		✓	✓	
South	Baltimore, MD	✓	✓	✓		✓		Guns
	Columbia, SC		✓					
	El Paso, TX		✓	✓	✓	✓	✓	Charity gifts; shoplifted merchandise
	Memphis, TN		✓	✓	✓	✓	✓	
	Miami, FL	✓	✓	✓	✓			Stolen/shoplifted merchandise/groceries
	New Orleans, LA	✓	✓	✓	✓	✓		Food Stamps
	Washington, DC	✓	✓	✓		✓		
Midwest	Chicago, IL	✓		✓				Drug buying services
	Detroit, MI	✓	✓	✓	✓		✓	"hit" other user's vein; buy/lookout for other users
	Sioux Falls, SD	✓	✓	✓				
	St. Louis, MO	✓	✓	✓		✓	✓	
West	Billings, MT	✓	✓	✓				
	Denver, CO	✓	✓	✓		✓	✓	Precursors
	Honolulu, HI		✓	✓	✓			
	Los Angeles, CA	✓	✓	✓	✓			
	Seattle, WA	✓	✓	✓	✓	✓		Food Stamps

Source: Law enforcement (L) and epidemiologic/ethnographic (E) respondents cars, or make wire transfers and bank deposits. In El Paso, cash from heroin sales works its way from the buyer through the various levels and eventually to Mexico via body carriers and vehicles and, recently, with purchases of money orders. In Seattle, money moves almost immediately, within a small geographic area, to the next tier of suppliers, usually carried on someone's person or by car or bus. Multi-tiered passing of drug money is also mentioned in Chicago, Memphis, and New Orleans.

Dealers dispose of cash from drug sales in many ways, according to law enforcement sources in many *Pulse Check* cities...

- **Money laundering:** Boston, Memphis, Miami, Portland (ME)
- **"Re-upping" supplies:** Baltimore, Columbia (SC), Honolulu, Los Angeles, Portland (ME), Sioux Falls, and St. Louis
- **Entertainment:** St. Louis
- **Passing money up the supply ladder:** Chicago, El Paso, Memphis, New Orleans, Philadelphia, and Seattle

What deters street drug buys? An intense and visible police presence is, by far, the most effective, albeit short-term, deterrent, according to law enforcement and epidemiologic/ethnographic sources. The other most commonly reported deterrents are other police interventions (such as anti-terrorist activities), media coverage, overdoses, supply or demand changes, neighborhood changes, and legislative/sentencing changes.

Several sources suggest additional deterrent measures that might be effective in their communities' future efforts:

- **Baltimore, MD**[L]: Knock down abandoned buildings.
- **Chicago, IL**[E]: Find legitmate jobs for people who sell drugs.
- **Los Angeles, CA**[E]: Make large local-level busts to force dealers indoors or stay low key.
- **Memphis, TN**[E]: Increase media coverage of drug-related crime to make more people afraid to buy drugs.
- **Portland, ME**[L]: Use the existing joint task force, which includes nearby Lawrence and Lowell, Massachusetts, to increasingly target suppliers from those areas.
- **St. Louis, MO**[E]: Target prevention efforts toward specific drugs, specific populations, and specific geographic areas.
- **Sioux Falls, SD**[L]: Give classes on methamphetamine lab detection to different community groups; try to get a precursor law that parallels the Federal law.

How have recent targeted law enforcement or legislative policy directives or initiatives impacted on communities' drug problems? Law enforcement and epidemiologic/ethnographic sources report a range of recent initiatives, particularly those involving new precursor laws and other efforts targeting methamphetamine. Other widely reported efforts include targeting diverted OxyContin®, rescheduling other drugs, enacting stricter sentencing guidelines, and diverting offenders into treatment.

How can local drug market activity be disrupted in the future? *Pulse Check* law enforcement sources suggest a wide range of possible strategies. While these individual opinions do not reflect the views of any government entity, they might be of interest to decisionmakers and policymakers at the local, State, and Federal levels.

- Alter courts' focus to emphasize dealers, not users (for example, expand drug courts and in-custody treatment opportunities).
- Identify new legal drugs with abuse potential, and place them on the controlled list within 6 months. This strategy works better at the Federal level, where sanctions tend to be more punitive, than at the State level.
- Target out-of-State suppliers, because arresting local suppliers and dealers has a short-term effect.
- Map drug calls-for-service to help pinpoint locations for law enforcement activities.
- Increase community involvement.
- Enact more precursor laws at the Federal and State levels.
- Adopt stricter mandates and penalties for smaller drug dealers.
- Tax convicted drug dealers.
- Change local nuisance abatement laws to require more convictions over longer time periods.
- Strengthen existing laws to ensure that dealers are not released on technicalities.

Recent deterrents in specific *Pulse Check* communities...

An intense and visible police presence is, by far, the most effective, albeit short-term, deterrent, according to sources in 12 cities:

Baltimore[L,E]
Boston[L,E]
Chicago[L]
Denver[E]
Detroit[L,E]
El Paso[L,E]
Memphis[L]
New Orleans[L,E]
New York[L,E]
Philadelphia[L,E]
St. Louis[L,E]
Seattle[L,E]

Such a presence usually involves uniformed police or marked units. For example:

- **New York, NY**[L]: When police presence declines, drug activity increases, as was the case immediately after September 11.
- **Philadelphia, PA**[L,E]: The recent Operation Safe Streets project to deter drug market activities has placed uniformed police at more than 200 open-air corners. The effort has already had an impact—a decrease in outdoor drug sales and fewer potential buyers coming from Delaware, South New Jersey, and suburban Philadelphia areas. Sources report it is now easier to obtain larger wholesale-level quantities than smaller quantities.
- **St. Louis, MO**[L,E]: Police periodically target low-level dealers and arrest them all at the same time—a recent sweep, for example, focused on methamphetamine.
- **Seattle, WA**[L,E]: Such saturation takes two forms: in one organized semiannual interjurisdictional effort to disrupt the illegal drug market, a large number of uniformed police move into areas known for illegal drug activity; in a more episodic, spontaneous response to local merchants' complaints, an increased police presence is used to displace buyers and sellers, causing specific drug sales activities to be curtailed, at least temporarily.

Other police interventions: *Other types of police interventions, such as the following, have had deterrent effects in some cities.*

- **Baltimore, MD**[L]; **Billings, MT**[E]; **Los Angeles, CA**[L]; and **El Paso, TX**[L]: Undercover operations
- **Columbia, SC**[L]: An ongoing community-based operation involving an undercover officer assigned to make buys for a 1-month period, then arrest and issue sealed indictments to 15–20 sellers at a time
- **El Paso, TX**[L]: An undercover rave operation in December that stopped the spread of raves from New Mexico
- **Memphis, TN**[L]: Large sting operations; interdiction of outgoing parcels; increased intelligence on traffickers; anti-terrorist and money laundering operations and drug distribution operations
- **Miami, FL**[E]: A Federal and State coordinated effort to "clean up" cargo smuggling on the Miami River (While successful, it has also dispersed that type of trafficking to other small ports).
- **New Orleans, LA**[L]: Reverse stings
- **St. Louis, MO**[E]: Increased surveillance activity along Highway 44 (main connection to Mexico)

Media coverage: *Deterrent effects have been noted after the following.*

- **Boston, MA**[L]: Names of actual buyers and sellers published in newspapers
- **Memphis, TN**[E]: Media coverage of drug-related shootings (some involving young children) and methamphetamine lab seizures
- **Miami, FL**[E]: News stories about crack-sales-related violence
- **Portland, ME**[L]: A series of special articles on heroin, publicity about major arrests, and stories about recent methadone overdoses
- **Philadelphia, PA**[L]: Press stories about arrests
- **Sioux Falls, SD**[L]: Media publicity of recent drug busts

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Recent deterrents in specific *Pulse Check* communities (continued)...

A rash of overdoses:
The "scare" effects of recent overdose outbreaks are reported in several cities.

- **Boston, MA**[1]: Increases in overdoses have been a deterrent.
- **Columbia, SC**[2]: A recent increase in overdoses and overdose deaths, resulting from heroin being mixed with pure fentanyl, slowed down heroin purchases for a period of time.
- **El Paso, TX**[2]: Six heroin overdoses during the Mardi Gras season frightened some users into switching to other drugs or buying from other dealers.
- **Portland, ME**[1,2]: Heroin purchases slowed down following a dramatic increase in overdoses among the newer OxyContin® addicts who were switching to heroin. (These addicts had not built up the tolerance of old-time users, and they lacked an understanding about unpredictable heroin purity.)
- **St. Louis, MO**[2]: GHB is now rarely reported since a series of deaths 2 years ago.

Supply/demand changes:
Availability, price, and cash flow have had deterrent effects in some cities.

- **Baltimore, MD**[2]: Lack of availability
- **Columbia, SC**[2]: Periodic increases in marijuana prices
- **New Orleans, LA**[2]: Buyers' periodic lack of cash
- **St. Louis, MO**[2]: Price increases

Neighborhood changes:
Overt drug activity has declined in some cities following changes in the physical environment.

- **Boston, MA**[2]: Revitalization of neighborhoods, with businesses coming in, economic prosperity, and improved appearance
- **Boston, MA**[1]: Neighborhoods known to be strict
- **Chicago, IL**[2]: Gentrification of neighborhoods
- **Miami, FL**[1]: Nuisance abatement laws in nearby Ft. Lauderdale make property owners responsible for criminal activity. These laws are part of their city revitalization program, which approaches crime prevention through environmental design.

Anti-terrorist activities:
Drug-deterrent side effects are sometimes noted.

- **El Paso, TX**[1,2]: Shutting down bridges, checking cars, and heavy border patrols after September 11 had an immediate but short-lived effect on drug sales and trafficking.
- **Los Angeles, CA**[2]: Narcotics officers have been deployed to anti-terrorism efforts since September 11.
- **Portland, ME**[2]: The Canadian border has been tightened up since September 11.
- **Memphis, TN**[1]: In looking for terrorist activities, police are stumbling on drug operations.
- **Washington, DC**[1,2]: Tightened security since September 11 has also helped catch drug traffickers and dealers. On the other hand, dealers might be more brazen because they perceive that police have been diverted to anti-terrorism efforts.

Other deterrents:

- **Baltimore, MD**[1]: Using video cameras; changing two-way streets into one-way streets in order to make it more difficult to get to normal dealing locations

- Conduct street corner conspiracy investigations: have undercover officers make buys at one location from several people on several occasions; "follow the money" from runners to liaisons, to higher-ups, to money collectors, and so forth; charge all parties, not just those in possession; once the number of street dealers is depleted at a location, have other city and community agencies "clean up" the area; maintain an increased police presence.
- Continue public education activities, such as press releases and other efforts to increase media attention.
- Maintain a proactive approach to enforcement at the local level, similar to national-level agencies like the DEA or HIDTA.
- Expand drug courts and in-custody treatment.

The 20 *Pulse Check* epidemiologic/ethnographic sources were asked what gaps or challenges, if any, they perceive in their specific communities' current law enforcement efforts. These individuals offered several recommendations, including the following:

Recent initiatives have had impact in many *Pulse Check* cities...

New precursor laws and other efforts targeting methamphetamine:

- **Billings, MT[E]**: The area was recently designated as a methamphetamine high traffic area, enabling law enforcement to receive more funding.
- **Boston, MA[L]**: The precursor law has changed.
- **Denver, CO[E]**: Since a recent precursor law change, an offender can be arrested for only one or more precursors and does not have to be cooking them.
- **Detroit, MI[E]**: A methamphetamine task force was recently formed.
- **Los Angeles, CA[E]**: A new system targeting methamphetamine precursors limits the number of over-the-counter purchases and alerts the DEA to large-quantity purchases. Also, law enforcement efforts targeting farm robberies are aimed at methamphetamine manufacturers who rob fertilizer supplies from farms.
- **St. Louis, MO[E]**: Many efforts against precursor chemicals (not particularly new), such as laws and training of pharmacy staff about bulk purchases of cold medicines, have made it more difficult for people to cook methamphetamine, especially in rural areas.
- **Seattle, WA[E]**: A methamphetamine task force has raised citizen awareness about sights and smells that help locate labs in their own neighborhoods.
- **Seattle, WA[L]**: New methamphetamine precursor legislation, passed during the January–April statewide session, has increased the number of prohibited or restricted precursors.
- **Sioux Falls, SD[E]**: A methamphetamine awareness campaign includes community education. The recent increase in lab seizures may be due to the community's heightened awareness about what to look for.

Stricter sentencing:

- **Boston, MA[E]**: GHB has become a scheduled drug.
- **Denver, CO[E]**: GHB has recently become a Schedule I drug.
- **Detroit, MI[L,E]**: Ecstasy is now a Schedule I drug, with increased penalties for possession with intent to deliver.

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- Continue joint cooperation among various law enforcement and public health entities.
- Increase funding, staffing, and resources for various activities, such as: sustained police patrols; targeted efforts for prevention, education, and outreach; comprehensive data monitoring efforts; and research on trends, services, and policy.
- Simultaneously address the interrelated issues of illegal drugs and terrorism.
- Address treatment issues in conjunction with law enforcement efforts.
- Deal with problems unique to individual communities' geographic location, economic situation, and legislative policies.
- Pay more attention to diversion and illicit sales of prescription products.

Recent initiatives have had impact in many *Pulse Check* cities (continued)...

Efforts targeting diverted OxyContin®:	➤ **Columbia, SC[E]**: During a 4-month period while legislation removed OxyContin® from the Medicaid extension list, the number of clients abusing that drug declined. However, when the policy was rescinded or relaxed, the number rebounded and then surpassed earlier numbers. ➤ **Philadelphia, PA[L]**: Government rescheduling of diverted OxyContin®, and punitive action such as sentencing the infamous "Dr. Oxy" to 30 years in jail, have stopped the momentum. ➤ **Portland, ME[L,E]**: Numerous efforts regarding diverted OxyContin®, such as changes in prescription policies and educating prescribers, have caused declines since last year in the number of prescriptions and in the size of pharmacy stock. Consequently, availability of the diverted drug is down and prices are up. However, while these measures have affected buys, they have not affected use: some newer users have been switching to heroin.
Rescheduling of drugs:	➤ **Detroit, MI[L,E]**: Harsher sentences for trafficking large amounts of crack (more than 650 grams) has helped jail big dealers for life; however, now most traffickers avoid this law by dealing with smaller quantities. ➤ **Miami, FL[L]**: Stricter sentencing guidelines about 3 years ago resulted in the disappearance of flunitrazepam (Rohypnol) and the decline in dealers using firearms. A Weed and Seed program has lowered prosecution criteria to 5 grams, allowing prosecution of habitual drug dealers and preventing small dealers from falling through the cracks.
Diversion to treatment:	➤ **Honolulu, HI[E]**: A recent State Senate bill calls for diverting nonviolent first-time drug offenders into treatment. Not enough treatment slots, however, are available to do so. ➤ **Los Angeles, CA[E]**: Data regarding the impact of Proposition 36, which diverts nonviolent offenders from incarceration to treatment, will be analyzed after the county's different data systems are linked up. ➤ **Memphis, TN[E]**: A new alcohol and other drugs program for misdemeanor drug charges is expected to have a dramatic impact.
Other community efforts:	➤ **Los Angeles, CA[E]**: The Los Angeles Police Department's Narcotic Hotline and the Mayor's "We Tip" program provide for confidential reporting of drug activity in specific communities. ➤ **Portland, ME[E]**: Methadone clinics are now open 7 days a week. Previously, when clinics had been closed on Sundays, some clients who got extra doses on Saturday ended up selling them.

DRUG TREATMENT ISSUES

How available is methadone treatment in *Pulse Check* communities? Methadone maintenance is still not available in Billings or Sioux Falls. As reported in the past two *Pulse Check* issues, about half of the epidemiologic/ethnographic sources in the remaining cities—mainly in the South—consider methadone to be available in selected areas only, while the other half consider it available throughout their areas. Four sources (in Baltimore, Los Angeles, Seattle, and Washington, DC) report that methadone maintenance is somewhat more available since the last *Pulse Check*.

Five epidemiologic/ethnographic respondents report adequate capacity of public methadone maintenance, while seven (in Baltimore, Chicago, Detroit, El Paso, Honolulu, St. Louis, and Seattle) report having waiting periods of 1–12 months. Since the last *Pulse Check*, public methadone maintenance capacity has decreased somewhat in Chicago. Private capacity, however, has increased in four cities (Memphis, Miami, New Orleans, and Portland [ME]), although waiting lists are reported by six sources.

How has drug abuse impacted the health of clients in treatment? ***(Exhibit 1)*** Since the last *Pulse Check* reporting period, the impact of drug use on AIDS and HIV status seems to have stabilized in the majority of methadone and non-methadone programs, except as listed in exhibit 1. By contrast, reported cases of hepatitis C continue to increase among drug users in programs across the Nation, nearly always because of increased screening and awareness. High-risk pregnancies, drug-related auto

Exhibit 1.
How has illicit drug use impacted the health of users?

	City/Source	Adverse Conequence	Comments
HIIV/AIDS	Baltimore, MD^{N}	↑	
	Billings, MT^{N}		
	Philadelphia, PA^{M}		
	Seattle, WA^{M}		Increased particularly among Blacks and those who inject
	Washington, DC^{N}		Mostly due to unprotected sex and prostitution among drug users
	Columbia, SC^{M}	↓	
	Portland, ME^{N}		Heroin increased in potency so injection declined.
Hepatitis C	Baltimore, MD^{M,N}	↑	Unsafe sex, sharing needles
	Billings, MT^{N}		Sharing needles
	Boston, MA^{N}		More testing; 85 percent of patients are positive
	Chicago, IL^{M}		More testing; about 75 percent of clients are positive
	Denver, CO^{M,N}		More testing; 70 percent of clients are positive^{M}; many clients were originally diagnosed with hepatitis B, but have been retested with more sensitive tests that indicate hepatitis C
	El Paso, TX^{N}		Increases in injecting
	Los Angeles, CA^{M}		More testing has resulted in higher reported rates of hepatits C
	Miami, FL^{M}		More testing has resulted in higher reported rates of hepatits C
	Philadelphia, PA^{N}		More testing has resulted in higher reported rates of hepatits C
	Portland, ME^{M,N}		More testing has resulted in higher reported rates of hepatits C
	St. Louis, MO^{M,N}		More testing; large problem, especially among people older than 40
	Seattle, WA^{N}		
	Washington, DC^{M}		
	Memphis, TN^{M}	↓	
Auto Accidents	Billings, MT^{N}	↑	
	Columbia, SC^{M}		
	Washington, DC		
High-Risk Pregnancies	Billings, MT^{N}	↑	
	El Paso, TX^{M}		Clients are having unsafe sex and contracting STDs.
	Los Angeles, CA^{M}		
	Seattle, WA^{N}		
	St. Louis, MO^{M}		More women are presenting at hospitals.
	Washington, DC^{N}		Increasing, especially among young adults
	Columbia, SC^{M}	↓	
Overdoses	Billings, MT^{N}	↑	Related to prescription opiates, especially OxyContin® and methamphetamine; stronger methamphetamine now available and causing ODs
	Columbia, SC^{N,M}		Increases in drug combinations, especially alcohol and prescription pills, such as alprazolam (Xanax®) or hydrocodone (Vicodin®)
	Philadelphia, PA^{N}		Higher quality of heroin available
	Portland, ME^{M,N}		Increases in the combination of drugs including heroin, crack, and benzodiazepines
	St. Louis, MO^{M}		
	Philadelphia, PA^{M}	↓	
Tuberculosis (TB)	Baltimore, MD^{N}	↑	Related to crack and nicotine use
	Boston, MA	↓	
	Columbia, SC^{M}		
	Memphis, TN^{M}		
	St. Louis, MO^{M}		

Sources: Methadone and non-methadone treatment providers accidents, and overdoses (usually involving a combination of drugs) increased in several cities, but most levels remain stable. Tuberculosis (TB) has decreased in four cities and increased only in Baltimore.

What barriers face drug treatment in *Pulse Check* cities? *(Exhibit 2)* Methadone and non-methadone treatment programs across the country report many barriers to drug treatment. The most commonly mentioned barriers are limited slot capacity (a situation often caused by lack of funding), lack of trained staff to treat comorbid mental health disorders, and violent behavior among presenting clients. Several sources (in Chicago, Honolulu, Los Angeles, Portland [ME], St. Louis, and Seattle) report that funding has recently been cut, which has decreased slot capacities and increased waiting lists. Other common barriers to treatment include lack of transportation for potential clients and difficulty recruiting trained staff. Many programs cannot treat clients younger than 18 years, but these clients are often referred to programs designed especially for adolescents.

Have diagnoses of psychiatric comorbidity been shifting in treatment programs? Mood and conduct disorders are the most commonly reported mental health diagnoses among drug treatment clients, according to *Pulse Check* respondents. These types of diagnoses are generally stable, but increased levels or stable-at-high levels are reported in several cities:

Exhibit 2.
What are the barriers to drug treatment in different *Pulse Check* cities?

City	Limited slot capacity/ Waiting list	Lack of trained staff to treat comorbid clients	Violent behavior among clients	Comments	Other barriers
Baltimore, MD	✓	✓	✓	The program has 56 vacant slots but 545 on the waiting list. It is difficult to compete with private treatment programs' salaries for trained staff[M].	Difficulty recruiting trained staff due to change in the certification process[M]; lack of comprehensive services[M]; lack of transportation or money for transportation[N]
Billings, MT	✓	✓	✓	This program lacks licensed addiction counselors[N]. Disruptive behavior disorders, especially among younger clients, seem to be increasing and problematic[N].	
Boston, MA	✓		✓	This program turns away about 25 potential clients plus 3 drug treatment requests from jails per week[N].	Difficulty recruiting trained staff[M]; lack of recovery homes in the Boston area[N]
Chicago, IL	✓	✓	✓	The Illinois Department of Public Aid is cutting transportation by 75 percent[M]. Violence occurs if one particular gang is overrepresented within the program.[N]	Lack of transportation or money for transportation[M,N]; lack of medical doctors[M]; gang affiliation among clients[N]
Columbia, SC	✓	✓		These programs are hiring more staff within the next 6 months, so slot capacity should become more adequate[M,N].	
Denver, CO	✓	✓		Demand outweighs resources for this program, and the funding is perceived as inadequate[N]. Treatment programs seem to have either substance abuse or mental health treatment services, but there is not enough overlap[N].	
Detroit, MI	✓				Lack of trained staff[M]
El Paso, TX	✓	✓		More money and staff are needed to help with more clients[M].	

- **Billings, MT**[N]: Recent increases in several diagnoses—including conduct disorder, psychosis, mood disorder, and suicidal thoughts and attempts—reflect the overall increase in the use of illegal drugs.
- **Columbia, SC**[M]: An increase in conduct disorders has resulted from clients unhappy about being held accountable for positive urinalyses.
- **El Paso, TX**[N]: An increase in conduct disorders among the younger age group reflects improved diagnostic capabilities. An increase in suicidal ideations is also noted.
- **Memphis, TN**[N]: Comorbidity is stable at high levels, reflecting a major need for the community's jail system to triage with the mental health system. Prisoners often receive medication, such as antipsychotics, antidepressants, and mood stabilizers, while in jail. Often, however, they are released—sometimes at 2:00 or 3:00 a.m.—without discharge medications. Within a week, these individuals start decompensating. Some use cocaine or marijuana to stabilize their moods. Some end up in

Exhibit 2. ***(continued)***
What are the barriers to drug treatment in different *Pulse Check* cities?

City	Limited slot capacity/ Waiting list	Lack of trained staff to treat comorbid clients	Violent behavior among clients	Comments	Other barriers
Honolulu, HI	✓	✓	✓	Funding is low and has been cut recently due to a poor economy[N]. Violent behavior among presenting clients is methamphetamine related[N].	Lack of funding[M]
Los Angeles, CA	✓	✓		Funding has been cut recently[N]. Comorbid disorders have been increasing[N].	Lack of funding, especially among low-income adults[M]; lack of English language skills among students and parents[N]
Memphis, TN			✓		Lack of resources for drugs that don't require medical detox (especially marijuana and crack)[N]
Miami, FL	✓		✓	Funding is low[N].	Lack of in-home treatment resources[N]; lack of services to treat families as a whole[N]
New Orleans, LA	✓		✓		
New York, NY	✓	✓	✓	This program reports difficulty in hiring trained staff[M]. Many violent clients are mandated by the courts to participate in anger management courses[N].	Clients unable to pay[M]; lack of child care for clients[M]
Philadelphia, PA	✓	✓	✓	This program employs one psychiatrist with limited time per week, so they refer psychosis patients to mental health facilities that may lack expertise in substance addiction[N].	Low reimbursement rates[M]
Portland, ME	✓	✓		This program reports chronic waiting lists[N]. The barrier of lack of trained staff to treat comorbid disorders is improving[N].	
St. Louis, MO	✓	✓		Many State-funded detox services were cut recently[N].	Lack of State funding[N]; lack of safe, healthy, affordable, drug-free housing[N]
Seattle, WA	✓			One hundred people are currently wait-listed, and public subsidy slots have been filled since the beginning of year[M]. In the last 6 months, capacity has been halved due to funding cuts[N].	Lack of mental health services in the county[M]; lack of inpatient care[M]
Sioux Falls, SD	✓				Lack of funding[N]; families not following recommendations[N]
Washington, DC	✓				

emergency departments and are subsequently referred to treatment.

- **St. Louis, MO**[M]: Treatment staff are more aware of dual diagnoses than in the past and are working more closely with mental health centers. They are therefore increasingly diagnosing conduct disorders, mood disorders, and suicidal thoughts and attempts.
- **St. Louis, MO**[N]: The recent opening of an adolescent drug treatment program has led to an increase in diagnoses of conduct disorders. Additionally, large funding cuts in the private sector have led to more people with drug-related psychosis, schizophrenia, depression, and bipolar disorders being referred to this program.
- **Seattle, WA**[M]: An apparent increase in comorbidity diagnosis numbers actually reflects an increase in ancillary services.

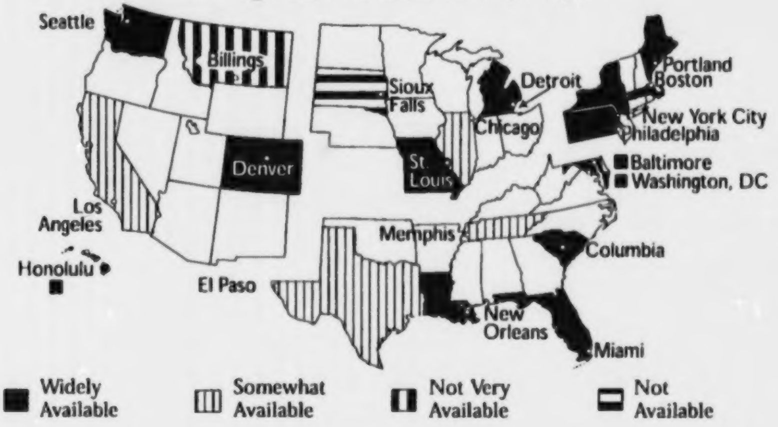
HEROIN*

Only seven sources in five cities (Boston, Philadelphia, Portland [ME] in the Northeast and Baltimore and New Orleans in the South) consider heroin the most commonly used drug (methadone treatment sources are excluded from that count because heroin is nearly always the most commonly used drug in those programs). However, heroin, more than any other drug, contributes to the most serious consequences—that is, medically, legally, societally, or otherwise—according to 31 sources in 15 cities: all four cities in the Northeast; Baltimore, Columbia (SC), El Paso, New Orleans, and Washington, DC, in the South; Chicago, Detroit, and St. Louis in the Midwest; and Denver, Los Angeles, and Seattle in the West.

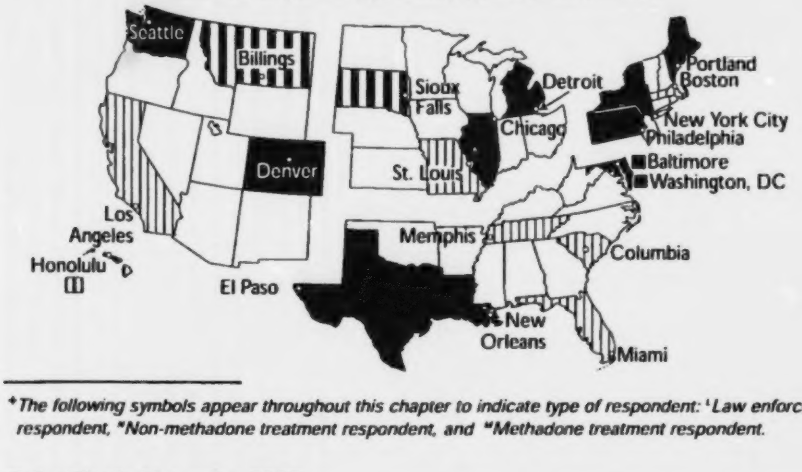
Compared with the last *Pulse Check* reporting period, the non-methadone treatment source in Washington, DC, believes that heroin has replaced crack as the drug contributing to the most serious consequences, and two sources in Portland believe that heroin has replaced pharmaceutical opiates and diverted OxyContin® (oxycodone hydrochloride controlled-release) as the drug with the most serious consequences. Similarly, heroin has replaced cocaine as the most commonly used drug according to sources in two southern cities: El Paso and New Orleans. According to the law enforcement source in Portland, it has replaced marijuana as the most commonly used drug.

Exhibit 1.
How available is heroin across the 20 *Pulse Check* cities (spring 2002)?

According to law enforcement sources (N=20)...


Seattle
Billings
Sioux Falls
Detroit
Portland
Boston
New York City
Philadelphia
Chicago
Denver
St. Louis
Baltimore
Washington, DC
Los Angeles
Honolulu
Memphis
Columbia
El Paso
New Orleans
Miami
Widely Available
Somewhat Available
Not Very Available
Not Available

According to epidemiologic/ethnographic sources (N=20)...


Seattle
Billings
Sioux Falls
Detroit
Portland
Boston
New York City
Philadelphia
Chicago
Denver
St. Louis
Baltimore
Washington, DC
Los Angeles
Honolulu
Memphis
Columbia
El Paso
New Orleans
Miami

HEROIN: THE DRUG

How available is heroin—in its various forms—across the country? *(Exhibits 1, 2, and 3)* More than half (23) of the 40 *Pulse Check* law enforcement and epidemiologic/ethnographic sources consider heroin widely available in their communities. Sources in the Northeast and South continue to report wider heroin availability than their counterparts in the Midwest and West. Only four sources in two cities (Billings and Sioux Falls) consider heroin not or not very available.

As reported in the last several issues of *Pulse Check*, high-purity snortable South American (Colombian) white heroin is the most common type, especially in the Northeast. Mexican black tar, a lower purity, injectable heroin, follows as the most common type and is widely available in most western *Pulse Check* cities. Southwest Asian heroin is the least available of the types of heroin and is considered widely available only in Chicago and New Orleans. Southeast Asian heroin is considered widely available only in New Orleans, Portland (ME), and Washington, DC.

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*The following symbols appear throughout this chapter to indicate type of respondent: Law enforcement respondent, Epidemiologic/ethnographic respondent, Non-methadone treatment respondent, and Methadone treatment respondent.

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Heroin availability remained stable between fall 2001 and spring 2002, according to the majority of law enforcement and epidemiologic/ethnographic sources. In Philadelphia, availability declined, according to the law enforcement source; however, availability reportedly increased in six sites across the country. Similarly, the various forms of heroin remain generally stable in availability, with exceptions listed in Exhibit 3.

Exhibit 2.
How has overall heroin availability changed (fall 2001 vs spring 2002)?

Boston, MA^{E}
Columbia, SC^{E}
Denver, CO^{L}
Memphis, TN^{L}
Miami, FL^{E}
Portland, ME^{L,E}

Baltimore, MD^{L,E}
Billings, MT^{L,E}
Boston, MA^{L}
Chicago, IL^{L,E}
Columbia, SC^{L}
Denver, CO^{E}
Detroit, MI^{L,E}
El Paso, TX^{L,E}
Honolulu, HI^{L,E}
Los Angeles, CA^{L,E}
Memphis, TN^{E}
Miami, FL^{L}
New Orleans, LA^{L,E}
New York, NY^{L,E}
Philadelphia, PA^{E}
St. Louis, MO^{L,E}
Seattle, WA^{L,E}
Sioux Falls, SD^{L,E}
Washington, DC^{L,E}

Philadelphia, PA^{L}

Exhibit 3.
Which heroin varieties have changed in availability (fall 2001 vs spring 2002)?

Colombian
Boston, MA^{E}
Chicago, IL^{L,E}
Miami, FL^{E}
Portland, ME^{L}

Mexican black tar
Denver, CO^{L}
Los Angeles, CA^{L}
Memphis, TN^{L}
New York, NY^{L}

Mexican brown tar
Denver, CO^{L}
Los Angeles, CA^{L}
Memphis, TN^{L}
Miami, FL^{E}

Southeast Asian
Detroit, MI^{E}
Memphis, TN^{L}
Portland, ME^{E}

Southwest Asian
Baltimore, MD^{L}
Chicago, IL^{E}
Detroit, MI^{E}
New York, NY^{L}
Portland, ME^{L}

Colombian
Philadelphia, PA^{L}

Mexican black tar
New York, NY^{E}

Mexican brown tar
New York, NY^{E}

Southeast Asian
Chicago, IL^{E}
New York, NY^{E}

Southwest Asian
New York, NY^{E}

How pure is heroin across the country? *(Exhibit 4)* Similar to reports in the last *Pulse Check*, according to law enforcement and epidemiologic/ethnographic sources, street-level South American heroin ranges from 40 to 95 percent, with both extremes reported in Philadelphia. Also, as reported in the last *Pulse Check*, street-level Mexican black tar heroin ranges in purity from 8 percent in Denver to 70 percent in Billings. Purity levels remained stable in most *Pulse Check* cities with a few exceptions: they increased in two northeastern cities (New York^{E} and Portland [ME]^{L,E}), and they declined in Baltimore^{E} and Los Angeles^{E}.

A wide range of heroin adulterants (especially lactose-based additives and baby laxatives) continues to be reported by law enforcement, epidemiologic/ethnographic, and treatment sources, particularly in the Northeast and South. Quinine is a new adulterant (used to increase the heroin "rush") since fall 2001 according to sources in several cities, including Detroit, Portland, and Washington, DC. Other adulterants reported as new this reporting period include cocaine in Portland, "Golden Seal" and milk thistle (additives found at health food stores) in St. Louis, and meat tenderizer and flour in Washington, DC.

What are street-level heroin prices across the country? *(Exhibit 4)* As reported during the last two reporting periods, one dose (0.1 gram) sells for as little as $4 for South American heroin in Boston to as much as $120 for Mexican black tar in Seattle. Sources report declining prices, especially for larger quantities of the drug, in six cities in the Northeast and West: Baltimore^{E} (for

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Exhibit 4.
What are the prices and purity levels of different types of heroin in 19 *Pulse Check* cities?*

		MOST COMMON STREET UNIT				1 GRAM	
	City/Source	Unit	Size	Purity**	Price**	Purity**	Price**
South American white	Baltimore, MD^{L,E}	pill, "10 bag," capsule	NR	down	$10	NR	$100–$150 down
	Boston, MA^{L}	"bundle"	0.1 g	≥80%	$4–$6	NR	NR
	Miami, FL^{L}	NR	1 oz	NR	$2,100/down	NR	NR
	New York, NY^{E}	"bag"	0.1 g	70%/up	$10	≥70%/up	$90–$100
	New York, NY^{L}	"bag"	NR	80–90%	$10–$14	80–90%	$60–$74
		NR	1 oz	80–90%	$2,000		
	Philadelphia, PA^{E}	"hit"	NR	71%	$10	NR	NR
	Philadelphia, PA^{L}	"bag"	0.3 g	40–95%	$10–$20	70–75%	$75–$300
		"bundle"	10–13 bags	40%	$100		
	Portland, ME^{L}	"bag"	0.1 g	≥70–75%/up	$20–$25/down	NR	NR
Mexican black tar or brown	Billings, MT^{E}	"bundle"	1 g	50–70%	$260	50–70%	$260
	Denver, CO^{E}	NR	1 oz	40%	$2,000–$3,000	8–64%	$100–$150
	El Paso, TX^{E}	"dime," "deime"	2–3 person hit	NR	$2.50–$3	NR	NR
	El Paso, TX^{L}	NR	0.1 g	NR	$20	NR	NR
	Honolulu, HI^{E}	"paper"	0.25 g	25%	$50–$75	25%	$150–$200 down
	Honolulu, HI^{L}	"bundle"	0.1 g	NR	$50–$75	NR	$150–$300
	Los Angeles, CA^{E}	"Mexican ounce"	25 g	down	$600–$700/down	16–18%/down	$90–$100
	Los Angeles, CA^{L}	"balloon"	0.1 g	NR	$20/down	NR	NR
	Memphis, TN^{E}	vial	NR	NR	$25–$30	NR	$100
	Memphis, TN^{L}	NR	0.1 g	NR	$50	NR	$400–$450
	Seattle, WA^{E}	NR	NR	NR	NR	15–25%	$40–$65
	Seattle, WA^{L}	NR	0.1 g	14–58%	$90–$120	NR	NR
Unspecified type	Chicago, IL^{E}	"dime bag"	NR	NR	$10	NR	$50–$300
	Chicago, IL^{L}	"hit"	0.2 g	NR	$20	NR	$150
	Columbia, SC^{L}	"bundle"	2 g	NR	$225	NR	$125–$130
	Detroit, MI^{E}	"hit"	NR	20–70%	$10	NR	NR
		"bundle"	10–12 hits	20–70%	$100–$200		
	Detroit, MI^{L}	"dime"	0.1 g	NR	$10	NR	$100–$150
	New Orleans, LA^{E}	NR	NR	NR	NR	NR	$300–$600
	New Orleans, LA^{L}	"foil," "hit"	0.5 g	7%	$20–$25	NR	NR
	St. Louis, MO^{E}	NR	1 g	NR	$100	NR	$100
	Washington, DC^{E}	"bone" (unadulterated)	NR	40–80%	NR	NR	NR
		"bag" (white)	NR	NR	$8, $10, and $20	23%	$120–$150
	Washington, DC^{L}	"dime bag" (white)	50–75 mg	10–15%	$10	60–70%	$120–$140

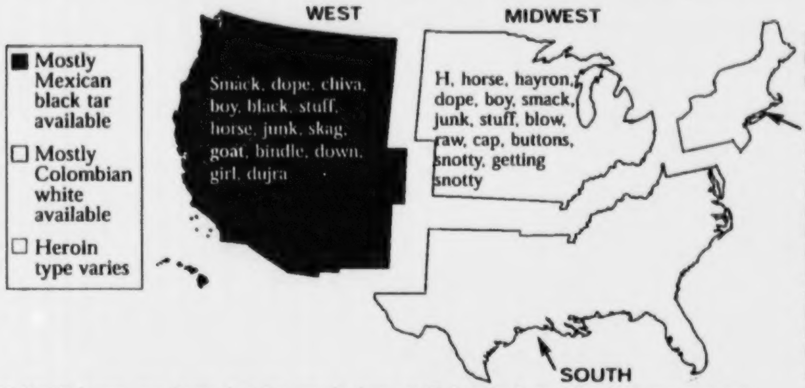
Sources: Law enforcement and epidemiologic/ethnographic respondents
**Respondents in Sioux Falls did not provide this information. **Changes since fall 2001 are noted as "up" or "down."*
NR=not reported

gram quantities), Boston^{E}, Honolulu^{E} (for larger quantities), Los Angeles^{L,E}, Miami^{L} (for ounce quantities), and Portland (ME)^{L,E}. High-end prices increased according to the epidemiologic source in Detroit.

How is heroin referred to across the country, and how are brand names and packaging used as marketing tools? *(Exhibit 5)* As reported in the last *Pulse Check*, street names and brand names proliferate in the Northeast and the South and are rarer in the Midwest and the West. Slang terms often refer to the heroin packaging: for example "brown bag" refers to the packaging in Memphis and "joint" refers to one plastic bag of heroin in Washington, DC. Often the slang term alludes to

Exhibit 5.

How is heroin referred to, and what types of heroin predominate, in the four regions of the country?*


■ Mostly Mexican black tar available
☐ Mostly Colombian white available
☐ Heroin type varies
WEST
MIDWEST
SOUTH

WEST

Smack, dope, chiva, boy, black, stuff, horse, junk, skag, goat, bindle, down, girl, dujra

MIDWEST

H, horse, hayron, dope, boy, smack, junk, stuff, blow, raw, cap, buttons, snotty, getting snotty

NORTHEAST

H, big H, horse, dope, smack, junk, product, boy, brother, bags, packets, dimes, dees, diesel, downtown, manteca (=lard), pabajomud, mud

103.9, 747, 8-ball, 911, allen figure, allen iverson, bad habit, bart simpson, batboy, big mac, bingo, body bag, bomb, bull dog, bumble bee, cobra, cold water, colt 45, creeper power, DOA, demolition, devil, devil's advocate, diesel dmx, DINOSAUR, doo-wop, double nut, dracula, eagle, fatal, fingers, ghost, godfather, happy face, holyfield, homicide, hot water, I'll be back, it's hot, k & a, knock out, land rover, legend, lexus, life, life after death, lucifer, maggie 2, magnum 357, marijuana leaf, mike tyson, monkey business, MONICA LEWINSKI, mvp, nautica, nike, no joke, NO MONEY, number one, old navy, one and done, one hundred percent, one life, one way, opium, pac man, pain killer, playboy, playing cards, polo, poison, purple haze, red devil, RED HOT, river, rush, samurai, scorpio, scorpion, SPADES, suicide, super a, super buick, super hot, super nautica, thumbs up, timberland, titanic, tnt, tomahawk, tommy hilfiger, too strong, TOP DOG, toyota, trinidad, unicorn, ups, usa, viper, wcw, white control, white house

SOUTH

H, big H, heron, ron, horse, boy, he, smack, dope, stuff, doogie, doozy, diesel, tammy, manteca, foil, papers, brown bag, brown, chiva (=goat), train, old garbage, dog food, s**t, carga, joint, billie, negra (Mexican black tar), negro, scramble (low purity), bone (high purity), raw (very high purity) *10 PACK, 747,* ***big doodig,*** *BIN LADEN, HOLY TERROR, jerry springer, murder one, no limit, pink hearts, playboy, pluto, skull and crossbones, white dragon*

**Italics refer to dealer brands, which are sometimes interchanged with user street names. Names in all caps are new this reporting period.*
Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

the type of heroin sold: "tar," "black," and "negra" (referring to Mexican black tar heroin) are common slang terms in the South and West, and "china" or "china white" (referring to Southeast Asian powder heroin) are common slang terms reported in Billings, Chicago, Honolulu, Los Angeles, and Memphis.

Dealers use brand names as marketing devices so that buyers can recognize heroin quality and return to that particular dealer for future sales. Brand names tend to change often, especially if buyers recognize a particular brand as low quality or if a dealer suspects that law enforcement personnel are able to connect a heroin brand to a dealer. During this reporting period, 7 new brand names were reported in the Northeast (compared with 18 new ones last reporting period just in Philadelphia) and 5 in the South. Although brand names are still common in the Northeast and South, they are becoming less common in several cities, including Boston, where dealers fear that labels and brand names may make them vulnerable to law enforcement, and in Philadelphia.

Heroin packaging continues to vary widely in most *Pulse Check* cities, with the most common packaging continuing to be plastic, cellophane, glassine, or coin bags, often the zipper type. Other common packaging includes balloons and "bindles," in which the heroin is folded, often made of foil, paper bags, plastic wrap, wax paper, magazine pages, or lottery tickets.

Brands can also be identified by the color of the bag in which heroin is sold (as in Boston, Portland [ME], and Washington, DC) or the color of the balloon in which it is sold (as in Memphis). According to the law enforcement source in Chicago, dealers are no longer inserting popcorn kernels or colored pieces of candy into the plastic heroin-filled bags to identify dealers.

Less common packaging includes condoms in New York; capsules, gel caps, and small glass vials in Baltimore; vials in Memphis; pellets in New Orleans; "seal-a-meals" (heat-sealed plastic bags) in Portland, and brown packing tape inside of duct tape in St. Louis. In El Paso, heroin is wrapped in foil inside a balloon so that dealers can put it in their cheeks or swallow it if they deem it necessary. In Detroit, the variety of heroin packaging has widened since the last reporting period. In Boston, since the last reporting period, packaging has moved toward grams and fractions of grams and away from $10 bags, bundles, and bricks. Because the "grams" are not weighed and are in rock form

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("eggs"), this marketing technique enables the dealers to convince the buyer that they are getting more heroin for their money.

HEROIN: THE MARKET

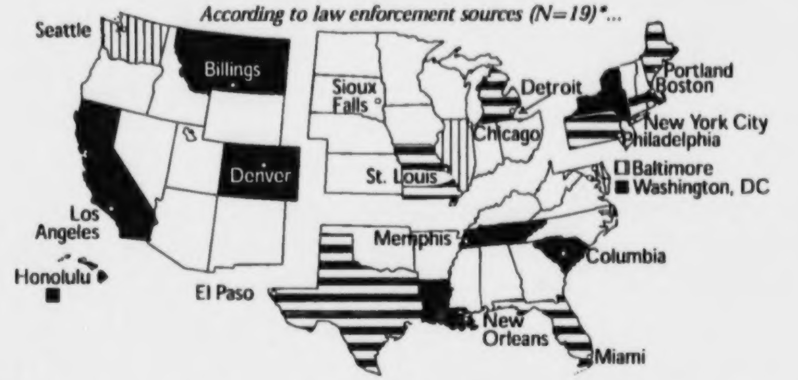
Who sells heroin? *(Exhibit 6)* Heroin sellers are more likely to be independent than organized, especially in the West and South, according to law enforcement sources. Epidemiologic/ethnographic sources are more likely to report organized sales structures than their law enforcement counterparts, and law enforcement sources more often report both independent and organized structures in a particular city than their epidemiologic/ethnographic counterparts.

The intricacies and varieties of heroin sales organizations in many *Pulse Check* cities underscore the challenges in disrupting local markets:

- **Baltimore, MD^E^**: Most heroin sellers are highly organized because "to survive on the street you need someone to cover your back."
- **Denver, CO^E^**: Heroin sellers participate in polydrug distribution within small autonomous street cells.
- **Memphis, TN^E^**: Heroin sellers are highly organized on an international level.
- **Miami, FL^E^**: The organization of heroin sellers often depends on the location of the market. Heroin sellers in the streets tend to be independent, but when selling in the clubs, they tend to be organized in groups.
- **Philadelphia, PA^L^**: Although heroin dealers are mostly independent, some small organized groups work together for specific transactions, then separate, and then reform.
- **Portland, ME^L^**: Heroin sellers fall into two groups: independent and organized. Several organized groups travel to Lowell (in nearby Massachusetts) in cars, split into smaller groups as they return, and expand the number of people who distribute the drug after they return to Portland.
- **Seattle, WA^L^**: Heroin dealers fall into two types of structures: (1) street gangs and (2) loosely organized structures in which a "go-between" (a heroin addict who is a liaison between the buyer and the driver) and the driver (the person in the car who has the heroin) work together.

Exhibit 6.
How are street-level heroin sellers organized across the 20 *Pulse Check* cities (spring 2002)?

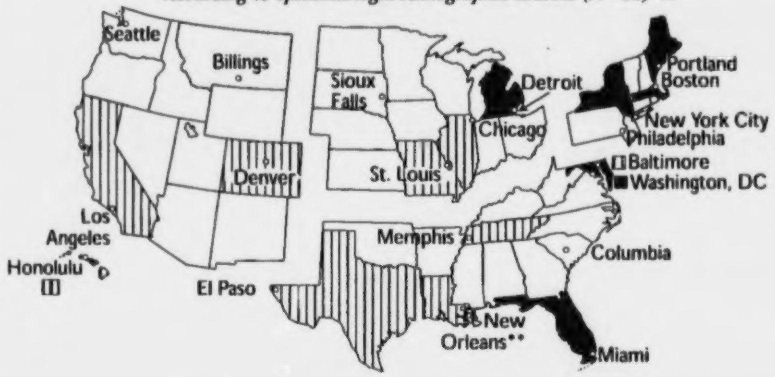
According to law enforcement sources (N=19)...*



Seattle
Billings
Sioux Falls
Detroit
Portland
Boston
New York City
Philadelphia
Chicago
Denver
St. Louis
□Baltimore
■ Washington, DC
Los Angeles
Memphis
Columbia
Honolulu
■
El Paso
New Orleans
Miami

■ Independent ▥ Organized ▤ Both Independent and Organized

According to epidemiologic/ethnographic sources (N=15)...*



Seattle
Billings
Sioux Falls
Detroit
Portland
Boston
New York City
Philadelphia
Chicago
Denver
St. Louis
□Baltimore
■Washington, DC
Los Angeles
Memphis
Columbia
Honolulu
▥
El Paso
New Orleans**
Miami

** The law enforcement source in Sioux Falls did not respond. The epidemiologic/ ethnographic sources in Billings, Columbia (SC), Philadelphia, Seattle, and Sioux Falls did not respond.*
*** This source defined the level of organization as "very loose."*

Law enforcement and epidemiologic/ethnographic sources continue to report young adults (18–30 years) as the most common age group of heroin sellers, but adolescents are sometimes reported. Epidemiologic sources report adolescents more often than do law enforcement sources, and law enforcement sources report older adults (30 years and older) more often than their epidemiologic counterparts.

Only a few law enforcement and epidemiologic sources report any new seller groups or structural changes this semester in *Pulse Check* cities:

- **Baltimore, MD^{L}, and Washington, DC^{E}**: Heroin sellers are reportedly younger than they were during the last reporting period.
- **Boston, MA^{E}**: Sellers are more independent, and sales continue to decentralize. Nearly all sellers now use beepers and cell phones, and many users support their heroin habits by selling the drug.
- **Portland, ME^{L}**: The organizational structure of heroin dealers is new this reporting period. In the past, dealers were independent locals, but they are increasingly working together.

According to law enforcement and epidemiologic/ethnographic respondents, heroin sellers often use the drug, with 36 percent of respondents reporting them as very likely to use the drug, and 30 percent reporting them as somewhat likely to use the drug. In this respect, they resemble crack and powder cocaine dealers, but differ from marijuana, methamphetamine, and ecstasy dealers, who are even more likely to use the drug that they sell *(see Highlights Exhibit 8)*.

How is street-level heroin marketed? Although open-air heroin markets continue to operate in several cities (Chicago, Detroit, Denver, Honolulu, Seattle, and Washington, DC), "underground" sales are common, requiring a wide range of law enforcement strategies to disrupt markets. Dealers commonly employ counterstrategies such as using beepers or cell phones to arrange meetings for the exchange of the drug with buyers (as reported in Boston^{L}, Honolulu^{L}, Portland [ME]^{L}, Memphis^{L}, Los Angeles^{L}, Seattle^{L}, and St. Louis^{E,L}) and creating multitiered marketing structures (as reported in Baltimore^{L}, Chicago^{L}, and Detroit^{L}). Examples of how heroin markets vary from city to city include:

- **Baltimore, MD^{L}**: A multilayered heroin market, involving a "touter," "runner," and "dealer," is used because sellers will not sell to anyone they don't know. The touter stands on the street advertising the drug and exchanges money for heroin with the buyer; the runner is the liaison between the touter and the dealer; and the dealer supplies the heroin.
- **Boston, MA^{L}**: Heroin sellers create a small list of customers to whom they will sell the drug. When contacted by a customer, the seller delivers the drug to a common meeting place or the customer's house.
- **Chicago, IL^{L}**: Heroin is sold discreetly inside, with several layers of people selling the drug. For example, on one floor of a house or building a buyer requests heroin, on the next floor the buyer pays for the drug requested, on the next floor someone tells the buyer where to go to obtain the drug, and finally the buyer goes to that location to obtain the drug.
- **Columbia, SC^{L}**: A contact will direct heroin buyers to a house or around a supermarket. When a buyer's car arrives at that place, a dealer will approach him/her for a sale.
- **El Paso, TX^{L}**: Most sales occur indoors after a buyer has been introduced to a seller through a common acquaintance.
- **Philadelphia, PA^{L}**: In certain neighborhoods, customers will drive by, roll down the car window, and buy the drug.
- **St. Louis, MO^{E,L}**: Buyers must place their "orders" for drugs to the dealer, and then the drug is exchanged hand-to-hand.

What other drugs do heroin dealers sell? *(Exhibit 7)* Heroin dealers continue to sell additional drugs in all *Pulse Check* cities, except for Billings, New York, and Philadelphia, where heroin is sold by itself. Additional drugs most often reported as sold with heroin are crack and powder cocaine. No changes are reported since fall 2001.

What types of crimes are related to heroin sales? Nonviolent and violent crimes are equally involved in heroin sales, according to 20 law enforcement and epidemiologic/ethnographic sources. Common violent crimes include assaults with weapons in New York, Portland (ME), St. Louis, and Washington, DC; gun sales in Philadelphia; rape in Memphis; and homicides in Portland. Reported nonviolent crimes include burglary in Detroit, Memphis, New York, and St. Louis; petty theft and shoplifting in Boston, Memphis,

Exhibit 7. What other drugs do heroin dealers sell?*

	City	Crack	Powder Cocaine	Marijuana	Other	No other drug sold
Northeast	Boston, MA					✓
	New York, NY	✓	✓	✓	Ecstasy	
	Philadelphia, PA					✓
	Portland, ME				OxyContin® and other pharmaceutical opiates	
South	Baltimore, MD	✓	✓	✓		
	Columbia, SC	✓				
	El Paso, TX	✓	✓	✓	Rohypnol (flunitrazepam)	
	Memphis, TN	✓	✓	✓	Pharmaceutical opiates	
	Miami, FL	✓	✓		Ecstasy	
	New Orleans, LA	✓				
	Washington, DC	✓	✓			
Midwest	Chicago, IL	✓	✓			
	Detroit, MI	✓				
	St. Louis, MO	✓	✓	✓		
West	Billings, MT					✓
	Denver, CO	✓	✓	✓	Methamphetamine	
	Honolulu, HI				Varies widely	
	Los Angeles, CA	✓	✓			
	Seattle, WA	✓	✓	✓	Benzodiazepines	

Sources: Law enforcement and epidemiologic/ethnographic respondents
**Respondents in Sioux Falls did not provide this information.*

Philadelphia, Portland, and Washington, DC; petty embezzling in Boston; forgery in Portland; and money laundering in Miami. The epidemiologic source in Portland notes that violence related to heroin sales has increased since the last reporting period.

Prostitution, especially on the part of the users, is reported by 18 law enforcement and epidemiologic/ethnographic sources in all regions of the Nation, and gang-related activities are reported by 15 law enforcement and epidemiologic/ethnographic sources in all the regions. According to the law enforcement source in Denver, gang-related activity has increased since the last *Pulse Check* reporting period.

Where are heroin markets located? Law enforcement and epidemiologic/ethnographic sources continue to agree that most heroin markets are located in central city areas. Additionally, suburban areas are mentioned in Denver, Miami, and St. Louis, and "all areas" are reported in El Paso, Memphis, Miami, New Orleans, New York, and Portland (ME). According to the law enforcement source in Denver, the market continues to shift geographically from central city areas to the suburbs.

Heroin markets continue to be located in open-air markets on streets or on street corners according to law enforcement sources in every city except for Sioux Falls, where heroin is rarely available. The next most common market settings continue to be around public housing developments and inside private residences (as reported in 16 cities each). Crack houses are reported market settings in 10 cities across all 4 regions. Heroin is also commonly sold inside cars, as reported in 10 cities located in the Northeast, South, and West. Parks, nightclubs and bars, junior high and high schools, private parties, hotels and motels, and areas around drug treatment clinics continue to be mentioned as common heroin market locations in various cities.

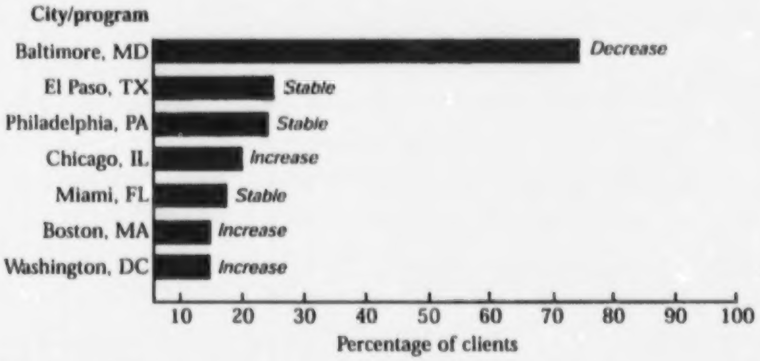
The heroin market has expanded to include new locations in several cities since the last *Pulse Check* reporting period:

- **Denver, CO**[L]: New locations for heroin markets include junior high and high schools and private parties.
- **New Orleans, LA**[L]: Heroin markets used to be only around housing projects, but now they can be found in a wide variety of locations.
- **Philadelphia, PA**[L]: Heroin sales are beginning to move indoors or to other street corners to avoid law enforcement.
- **Portland, ME**[L]: Heroin sales have begun to take place around treatment clinics and inside hotels or motels.
- **Washington, DC**[L]: Since the last *Pulse Check*, five new open-air markets for heroin in particular have been opened, typically by dealers 16–18 years old.

HEROIN: THE USERS

How many heroin users are in treatment? *(Exhibit 8)* As would be expected, heroin is the primary drug of abuse among methadone treatment clients in nearly all *Pulse Check* cities. In Memphis, however, pharmaceutical opiates and benzodiazepines are the primary problems. Among non-methadone treatment clients in *Pulse Check* cities, primary heroin users range from a small percentage of

Exhibit 8.
Which non-methadone treatment programs in *Pulse Check* cities have substantial percentages* of clients reporting heroin as their primary drug of abuse? How have those percentages changed (fall 2001 vs spring 2002)?**



**15 percent or more*
***Non-methadone treatment sources did not respond in Denver and New Orleans.*

clients (0–5 percent) in places such as Billings, Columbia (SC), Detroit, Honolulu, Los Angeles, Memphis, New York, and Sioux Falls to a high of 75 percent of treatment clients in Baltimore.

Since the last reporting period, several non-methadone treatment programs in *Pulse Check* cities (Billings, Boston, Chicago, Portland [ME], Seattle, and Washington, DC) have reported increases in the number of heroin clients.

The Portland epidemiologic source notes that heroin use has increased, probably because OxyContin® abusers are switching to heroin, which is easier to obtain. Increases are also reported in three non-methadone treatment programs where the heroin population is small: Columbia (SC), Memphis, and New York. A decrease in heroin clients is mentioned by the non-methadone treatment source in Baltimore.

Methadone treatment sources report stable numbers and proportions of heroin clients since the last reporting period, except in Honolulu, where they decreased.

How do heroin clients wind up in treatment? According to non-methadone treatment sources, heroin clients are most likely to be referred to treatment by the criminal justice system. By contrast, methadone treatment sources report self-referrals (19 sources) as the most common type of referral, followed by referrals from the criminal justice system (8 sources). Mostly because drug courts are increasingly established in many *Pulse Check* cities, more heroin clients are being referred to methadone and non-methadone treatment by the criminal justice system, including those in Baltimore^{M}, Billings^{N}, New York^{M}, and Seattle^{M}.

Who uses heroin? As reported in previous *Pulse Checks*, heroin users tend to be White males, older than 30, of low socioeconomic position, who live in central city areas. However, demographics vary from city to city. For example, although adults (older than 30) predominate according to most sources, young adults (18–25 years) predominate according to sources in eight cities (Columbia [SC]^{M}, Denver^{N}, Miami^{E}, Philadelphia^{E,N}, Portland [ME]^{N}, Sioux Falls^{E}, St. Louis^{N}, and Washington, DC^{N}), while adolescents predominate as heroin clients according to two sources (in Columbia^{N} and Denver^{M}). Mean ages range from 25 (Philadelphia^{N}) to 46 years (Washington, DC^{M}).

How do users administer heroin? *(Exhibit 9)* As reported in past *Pulse Check* issues, injecting remains the most commonly reported route of administration. Snorting, however, continues to predominate in many sites, particularly nonwestern sites.

Since the last reporting period, snorting has increased according to eight sources in seven cities: Baltimore^{E,M}, Boston^{N} (where purity has increased recently), El Paso^{M}, Memphis^{E} (where users reportedly have switched from injecting due to fear of HIV), Miami^{M} (where injecting has declined), New Orleans^{E}, St. Louis^{E} (where more new users are snorting). On the other hand, injecting has reportedly increased in Boston^{E} and Portland^{E,N}, where new hepatitis C cases in young adults are related to an increase in injection among that population.

What other drugs do heroin users take? In some cities, polydrug use remains the norm. Sources in Billings and Philadelphia, for example, explain that most treatment clients are polydrug users: they use whatever is available on the market. Cocaine (powder or crack) continues to be the most common drug used with heroin, often injected together as a "speedball." Marijuana (to extend the heroin effects), pharmaceutical opiates and benzodiazepines, and methamphetamine (where available) are also reportedly used with heroin. Shifts and variations are reported in the use of heroin and other drug combinations in several *Pulse Check* cities:

- **Boston, MA^{E}**: Because the veins of older heroin addicts collapse, many have shifted from injecting a combination of heroin and powder cocaine in a speedball to injecting heroin intramuscularly and, immediately after, smoking crack. Also, recent heroin initiates often combine pharmaceutical opiates, benzodiazepines, or marijuana with heroin.
- **Los Angeles, CA^{E}**: The use of pharmaceutical opiates (Vicodin®, OxyContin®, and methadone) and crack sequentially with heroin has increased.
- **Los Angeles, CA^{M}**: Methamphetamine used sequentially with heroin has increased.
- **Memphis, TN^{E}**: Amphetamines or PCP are sometimes used after heroin—a new development this reporting period.
- **Miami, FL^{E}**: New heroin users continue to use ecstasy after heroin to "parachute down."
- **Seattle, WA^{E}**: An emerging group of heroin users tends to take methamphetamine in combination with heroin.

Exhibit 9.
How do users administer heroin?

	Injecting is most common in...	Snorting is most common in...	Smoking is most common in...
Northeast	Boston, MA^{E,M} New York, NY^{M} Philadelphia, PA^{E,N} Portland, ME^{E,M*}	Boston, MA^{N} New York, NY^{E} Philadelphia, PA^{M} Portland, ME^{M*,N}	New York, NY^{N}
South	Baltimore, MD^{E*,M*} Columbia, SC^{E,M} El Paso, TX^{E,M,N} Memphis, TN^{E*,M,N} Miami, FL^{E,N} New Orleans, LA^{E*,N*} Washington, DC^{E,M}	Baltimore, MD^{E*,M*,N} Memphis, TN^{E*} Miami, FL^{M} New Orleans, LA^{E*,N*} Washington, DC^{N}	
Midwest	Chicago, IL^{N*} Detroit, MI^{E*,M} St. Louis, MO^{E,M,N*} Sioux Falls, SD^{E*}	Chicago, IL^{N*} Detroit, MI^{E*,N} St. Louis, MO^{N*} Sioux Falls, SD^{E*}	
West	Billings, MT^{M*} Denver, CO^{E} Honolulu, HI^{E,M,N} Los Angeles, CA^{E,M} Seattle, WA^{E,M,N}	Billings, MT^{E,M*} Denver, CO^{M**}	Denver, CO^{M**,N}

**Respondent considers injecting and snorting as approximately equal.*
***Respondent considers snorting and smoking as approximately equal.*
Note: The non-methadone treatment sources in Billings, Columbia (SC), Los Angeles, and Sioux Falls did not provide this information.

Where and with whom is heroin used? Nearly all epidemiologic/ethnographic and treatment sources continue to report that heroin is used privately and alone. Private residences and public housing developments remain the most common settings for heroin use. Several changes or interesting observations are noted since the last *Pulse Check*:

- **Boston, MA^{E}**: Other settings for heroin use include the hallways, stairwells, rooftops, and behind dumpsters of public housing developments; the parking lots of convenience stores and supermarkets; homeless shelters; public restrooms; and abandoned lots.
- **El Paso, TX^{E}, and Seattle, WA^{E}**: Use settings include bathrooms in fast food restaurants.
- **Memphis, TN^{E}**: Users increasingly take the drug alone in private residences.
- **New Orleans, LA^{E}**: Users increasingly take heroin in public, and motels are a new setting for its use.

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The changing nature of heroin users (fall 2001 vs spring 2002)...

Several sources report a younger cohort of heroin users, new since the last Pulse Check*:*

- **Boston, MA^{E}**: In blue-collar neighborhoods, some White adolescents (mean age 16) are beginning to inject heroin.
- **Boston, MA^{N}, and Portland, ME^{N}**: Heroin clients are now predominantly young adults, compared with the last reporting period when older adults predominated.
- **Miami, FL^{M} and New Orleans, LA^{E}**: Younger users (18–30 years) are coming into treatment more often than during the last reporting period.
- **Portland, ME^{E}**: The older group (older than 30) of heroin users is declining as the younger group (18–30 years) is increasing.
- **St. Louis, MO^{N}**: This program notes an increase in adolescent heroin use, but that may be because an adolescent treatment program was initiated last summer.
- **Seattle, WA^{E}, and Washington, DC^{E}**: More young adults are using heroin than in the past.

By contrast, several sources report an aging heroin-using population:

- **El Paso, TX^{E}**: Heroin users continue to age, and there are more adults (older than 30) than before.
- **Philadelphia, PA^{M}**: Heroin clients (mostly adults, 30 years and older) are continuing to age.
- **St. Louis, MO^{E}**: Although heroin users continue to age, the age of first use is dropping.

A few Pulse Check *sources in the South also note shifts in the race/ethnicity of heroin users:*

- **El Paso, TX^{M}**: Hispanics are the predominant heroin users, but more non-Hispanic Whites are coming in for treatment than during the previous reporting period.
- **Memphis, TN^{E}**: Whites have become the predominant group and are overrepresented compared with the general population.
- **Miami, FL^{M}**: Hispanics are the predominant heroin users, and more are coming in for treatment during this reporting period.

Other heroin users demographics have reportedly shifted in several Pulse Check *cities:*

- **Memphis, TN^{E}**: The trend is toward heroin use in private rather than in public places among White males who snort and inject.
- **Miami, FL^{E}**: The predominant heroin user residence has shifted from the central city area to the suburbs.
- **New Orleans, LA^{E}**: The predominant socioeconomic position of heroin users has shifted from lower to middle class, and use is spreading to all areas of the city.
- **St. Louis, MO^{M}**: Heroin clients are of low socioeconomic position and unemployed more often than before.

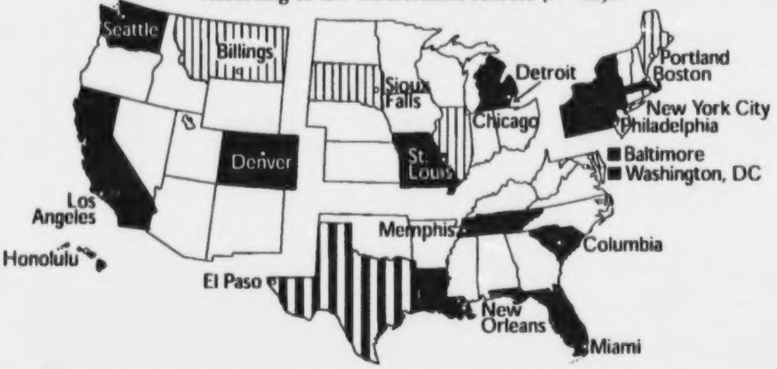
CRACK COCAINE*

Second only to heroin, crack is considered the drug contributing to the most serious consequences by 21 sources in 14 cities: Boston, New York, and Philadelphia in the Northeast; all 7 *Pulse Check* cities in the South; Detroit, Chicago, and St. Louis in the Midwest; and Los Angeles in the West—a region where most sources identify methamphetamine as the most serious drug problem. In nine of the cities (Chicago, Columbia [SC], Detroit, Los Angeles, Memphis, Miami, New Orleans, New York, and Washington, DC) where crack is named as the drug contributing to the most serious consequences, sources also consider it the most widely used illicit drug.

Compared with the last reporting period, crack replaced marijuana as the most widely used drug according to the epidemiologic source in Memphis. By contrast, heroin replaced crack as the most widely used drug, according to the epidemiologic source in New Orleans, and heroin replaced crack as the drug contributing to the most serious consequences according to the non-methadone source in Washington, DC.

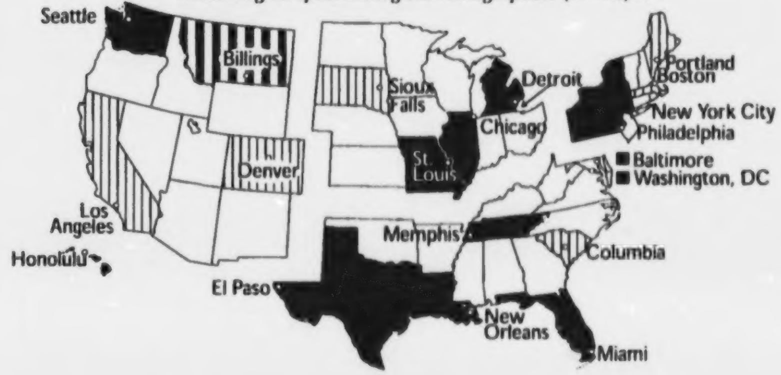
Exhibit 1.
How available is crack cocaine across the 20 Pulse Check cities (spring 2002)?

According to law enforcement sources (N=20)...


Seattle
Billings
Portland
Boston
Detroit
Sioux Falls
New York City
Chicago
Philadelphia
Denver
St. Louis
Baltimore
Washington, DC
Los Angeles
Memphis
Columbia
Honolulu
El Paso
New Orleans
Miami

■ Widely Available ▥ Somewhat Available ▮ Not Very Available

According to epidemiologists/ethnographers (N=20)...


Seattle
Billings
Portland
Boston
Detroit
Sioux Falls
New York City
Chicago
Philadelphia
Denver
St. Louis
Baltimore
Washington, DC
Los Angeles
Memphis
Columbia
Honolulu
El Paso
New Orleans
Miami

CRACK: THE DRUG

How available is crack cocaine across the country? *(Exhibits 1 and 2)* The majority of law enforcement (15 of 20) and epidemiologic/ethnographic (13 of 20) sources continue to consider crack widely available in their communities. Except for two sources (El Paso[L] and Billings[E]) who identify crack as not very available, the remaining sources consider it somewhat available.

As in the last *Pulse Check*, according to most law enforcement and epidemiologic/ethnographic sources, crack availability remained stable between fall 2001 and spring 2002, with declines noted by five sources in four cities (Boston, Honolulu, Philadelphia, and Seattle), and increases noted by four sources in four cities (Billings, Memphis, New York, and Sioux Falls).

How and where is crack cocaine made? Crack continues to be processed locally (from powder cocaine) in most *Pulse Check* cities, either by local distributors or by users. According to most sources, crack is processed locally because Federal guidelines for distributing crack are stricter than for powder; therefore, dealers would rather transport powder cocaine than crack.

The following symbols appear throughout this chapter to indicate type of respondent: [L] Law enforcement respondent, [E] Epidemiologic/ethnographic respondent, [N] Non-methadone treatment respondent, and [M] Methadone treatment respondent.

However, many sources, especially in the West, report crack as processed prior to arriving in their communities, including sources in Billings, Denver, El Paso, Honolulu, Portland (ME), Seattle, and Sioux Falls.

What are crack prices and purity levels across the country? *(Exhibit 3)* As reported in past *Pulse Checks*, crack prices remained stable in most cities, with exceptions in Los Angeles and Memphis, where prices declined. Crack is commonly sold by the rock (typically 0.1–0.2 grams) for $10–$20, respectively. Only a few street-level purity percentages are reported, and most are stable since the last reporting period:

- Los Angeles, CA^{E}: 80–85 percent pure
- New York, NY^{L}: 58 percent pure (up)
- Philadelphia, PA^{L}: 80 percent pure
- Portland, ME^{L}: 80 percent pure
- Seattle, WA^{L,E}: 40–85 percent pure
- Washington, DC^{L}: 30–60 percent pure

According to the law enforcement source in Memphis, in spring 2002, heroin traces were found in crack and powder cocaine seized by law enforcement, especially in the larger quantities seized. *Pulse Check* will continue to monitor this finding in upcoming issues.

How is crack referred to? *(Exhibit 4)* Few slang terms are reported as new in spring 2002, further indicating the relatively stable crack market across the country. New terms include "CDs" in the Northeast and "space" in the South.

Exhibit 2.
How has crack cocaine availability changed (fall 2001 vs spring 2002)?

Billings, MT^{L}
Memphis, TN^{E}
New York, NY^{E}
Sioux Falls, SD^{L}

Baltimore, MD^{L,E}
Billings, MT^{E}
Chicago, IL^{L,E}
Columbia, SC^{L,E}
Denver, CO^{L,E}
Detroit, MI^{L,E}
El Paso, TX^{L,E}
Honolulu, HI^{L}
Los Angeles, CA^{L,E}
Memphis, TN^{L}

Miami, FL^{L,E}
New Orleans, LA^{L,E}
New York, NY^{L}
Philadelphia, PA^{E}
Portland, ME^{L,E}
Seattle, WA^{L}
Sioux Falls, SD^{E}
St. Louis, MO^{L,E}
Washington, DC^{L,E}

Boston, MA^{L,E}
Honolulu, HI^{E}
Philadelphia, PA^{L}
Seattle, WA^{E}

How is crack packaged and marketed? In most cities, crack is packaged in a variety of ways. The most commonly reported packaging across all four regions remains small, plastic, cellophane, glassine, or coin bags, often the "zipper" type. Often crack is placed in a torn corner of a baggie and knotted ("Dominican knot"), folded in paper or magazine pages ("bindles"), or pieces of crack ("rocks") are sold without packaging ("loose"). Vials and aluminum foil are also common forms of packaging.

Similar to other marketing characteristics, few changes are noted in the packaging of crack cocaine. The New York epidemiologic source notes that, since fall 2001, packaging has switched from vials to colored baggies, with the colors representing crack purity or specific dealers. Only in one other city (Baltimore) are labels used—in that city, colored tops are used on vials of crack to identify dealers.

CRACK: THE MARKET

Who sells crack? Crack sellers are equally likely to be independent or organized (often as street gangs), and sources in six cities report independent and organized sellers as equally represented. Young adults continue to be the primary sellers in most cities, but adolescents are mentioned in six cities: Baltimore^{L,E}, Chicago^{E}, Columbia (SC)^{L}, Los Angeles^{L,E}, Memphis^{E}, and Seattle^{L}. Older adults are mentioned in five cities: Boston^{L,E}, Honolulu^{E}, Philadelphia^{L}, Sioux Falls^{L}, and St. Louis^{L}. Law enforcement and epidemiologic/ethnographic sources report no new seller groups since the last *Pulse Check*, further suggesting a stable crack market.

Similar to percentages for heroin and powder cocaine, about one-third of law enforcement and epidemiologic/ethnographic respondents report crack sellers as very likely to use the drug, and one-third report them as somewhat likely to use is the drug *(see Highlights Exhibit 8)*. The law enforcement source in El Paso explains that sellers process the crack because they are likely to use it. The Miami law enforcement source explains that in the city most street-level dealers are users, but county-wide, dealers don't use their own inventories. In Columbia^{L}, sellers commonly smoke marijuana blunts.

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How is crack marketed? Similar to marketing techniques for heroin, crack sales methods vary widely. In many cities, such as Boston, Columbia (SC), El Paso, Philadelphia, and Washington, DC, the particular technique for selling crack is identical to selling heroin. Many sources (in Columbia, El Paso, Memphis, Miami, Portland [ME], and Sioux Falls) report prearranged meetings for the exchange of crack. Open-air markets for crack are reported in seven cities (Chicago, Denver, Detroit, Honolulu, New Orleans, Seattle, and Washington, DC), and home delivery of the drug is reported in Boston and Miami. The law enforcement source in Sioux Falls points out that crack sellers avoid vulnerability to law enforcement by witholding large amounts of their crack inventory ("the stash") from the the street market. Since fall 2001, changes in marketing techniques are rare: in Boston^{L}, crack sales continue to be more "underground" than before, with more beeper and cell phone use.

What other drugs do crack dealers sell? No other drugs are reported as sold by crack dealers in Boston, Los Angeles, and Philadelphia, but in most cities crack dealers sell other drugs, especially heroin, powder cocaine, and marijuana:

- **Heroin sold by crack dealers:** Baltimore^{E}, Chicago^{E}, Denver^{E}, Memphis^{E}, Miami^{E}, New York^{L}, New Orleans^{E}, Portland (ME)^{E}, and St. Louis^{E}
- **Powder cocaine sold by crack dealers:** Billings^{L}, Chicago^{E}, Denver^{E}, El Paso^{E}, Memphis^{E}, Miami^{L}, and New York^{L}

Exhibit 3.
What are crack cocaine price levels in 19 *Pulse Check* cities?*

		MOST COMMON STREET UNIT		
	City/Source	Unit	Size	Price
Northeast	Boston, MA^{E}	1 g	1 g	$50
		rock	NR	$20
	Boston, MA^{L}	"jum" (small rock)	0.1 g	$10
	New York, NY^{E}	bag	NR	$5–$10
	New York, NY^{L}	rock, vial	NR	$20
		1 g	1 g	$24–$30
	Philadelphia, PA^{E}	rock	NR	$5
		"trey"	5-mm diameter rock	$3 or two for $5
	Philadelphia, PA^{L}	rock	0.1–0.5 oz	$50
	Portland, ME^{L}	rock	0.5 g	$100
South	Baltimore, MD^{E}	rock	NR	$5–$10
	Baltimore, MD^{L}	rock	NR	$10
	Columbia, SC^{L}	rock	NR	$20
		1 g	1 g	$100
	El Paso, TX^{L,E}	rock	0.25 g	$20
	Memphis, TN^{E}	rock	medium sized	$5
	Memphis, TN^{L}	rock	0.2 g	$20
	Miami, FL^{L}	rock	NR	$10–$20
	New Orleans, LA^{L,E}	rock	0.25–0.48 g	$10–$20
	Washington, DC^{L,E}	rock, "dime bag"	75 mg	$10
	Washington, DC^{L}	1 g	1 g	$100
Midwest	Chicago, IL^{E}	rock	NR	$5–$20
		1 g	1 g	$50–$150
	Chicago, IL^{L}	rock	0.2 g	$20–$25
		1 g	1 g	$123
	Detroit, MI^{E}	rock	NR	$20
	Detroit, MI^{L}	rock	0.1 g	$10
	Sioux Falls, SD^{L}	rock	small	$100
	St. Louis, IL^{L,E}	rock	NR	$20
		1 g	1 g	$300–$400
West	Denver, CO^{E}	rock	NR	$20–$30
	Denver, CO^{L}	rock	0.1–0.2 g	$20
		1 oz	1 oz	$950–$1,250
	Honolulu, HI^{E}	0.25 g	0.25 g	$25–$35
	Honolulu, HI^{L}	rock	0.25 g	$25–$30
		1 g	1 g	$100–$250
	Los Angeles, CA^{E}	1 oz	1 oz	$600–$700
		1 g	1 g	$80
	Los Angeles, CA^{L}	rock	0.2 g	$10
	Seattle, WA^{E}	rock	NR	$2, $5, and $10
	Seattle, WA^{L,E}	1 g	1 g	$100

**Sources in Billings did not provide this information.*
NR=Not reported
Sources: Law enforcement and epidemiologic/ethnographic sources

- **Marijuana sold by crack dealers**: Baltimore^{E}, Columbia (SC)^{L}, Denver^{L,E}, Detroit^{E}, El Paso^{E}, Honolulu^{L}, Miami^{L,E}, New York^{L}, Portland^{E}, St. Louis^{L,E}, Sioux Falls^{L}, and Washington, DC^{L}
- **Ecstasy sold by crack dealers**: Denver^{L}, Miami^{E}, New York^{L}, and Washington, DC^{L}
- **Methamphetamine sold by crack dealers**: Billings^{L}, Denver^{L,E}, and Honolulu^{L}
- **OxyContin® sold by crack dealers**: Miami^{L}

Since the last *Pulse Check*, only one change was reported in drugs sold by crack dealers: in Baltimore, marijuana is now sold by crack dealers.

Exhibit 4.
How is crack cocaine referred to in the four regions of the country?*

WEST
Rock, base, boulders, pebbles, soap, soup

MIDWEST
Rock, rock star, bird (32 oz), bopper, bumper, hard stuff, stone

NORTHEAST
Rock, bumps, freebase, jums, CDs, ice cubes

Rock, bullets, ma'a ("rock" in Samoan), pohaku

Rock, base, blow, bump, candy, coca, cookies, crumb, girl, hard, lady, loose, piedra, ready rock, scottie, shrile, SPACE, stones, twinkle, monkey nut (big rock), yam (big rock), bomb (100 rocks)
SOUTH

**Names in all caps are new this reporting period.*
Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

What types of crimes are related to crack sales? Crack sales are associated with prostitution, gang-related crimes, and violent crimes, more so than any other drug sales, according to the majority of law enforcement and epidemiologic/ethnographic respondents *(see Highlights Exhibit 7)*. Violent crimes include armed robberies in Chicago, New York, St. Louis, and Sioux Falls; assaults in New York and Washington, DC; street robberies in Los Angeles; and turf wars in Sioux Falls. No changes have been reported since fall 2001.

Where are crack markets located? More than two-thirds (23 of 33) of law enforcement and epidemiologic/ethnographic respondents across the Nation report central city areas as the primary location of crack sales. Markets are located primarily in suburban areas in El Paso; in central city and suburban areas in Los Angeles, Miami, and Portland (ME); and in all areas (central city, rural, and suburban areas) in Denver, Detroit, Memphis, New Orleans, and New York. The most common sales settings for crack remain streets (mentioned by all 20 law enforcement sources), crack houses, private residences, and around public housing projects.

Since the last reporting period, crack sales have moved predominantly into the central city areas of Memphis, and are spreading to all areas of New Orleans. In Philadelphia^{L}, crack sales have increasingly moved indoors and even outdoor sales are constantly moving from street corner to street corner to avoid law enforcement. In Portland, new crack sales locations since fall 2001 include crack houses and hotels or motels.

Marketing techniques in the East...

- **Baltimore, MD^{E}**: "Touters" stand on the street and advertise crack by referring to the colored tops on the vials in which crack is packaged: "black tops are good today." The colors of the vial tops change daily, and the sales locations move daily to avoid law enforcement.
- **Phildelphia, PA^{L}**: Most crack sellers are organized as small, loose confederations of individuals who work together for specific transactions, go their separate ways, and then re-form, making them difficult to track. Furthermore, Philadelphia streets are divided into neighborhoods and blocks, with someone "controlling" a particular block or neighborhood. If a dealer wants to sell a certain drug, he or she pays "rent" to the person who controls the area. This practice helps dealers evade law enforcement and often results in violent turf wars.

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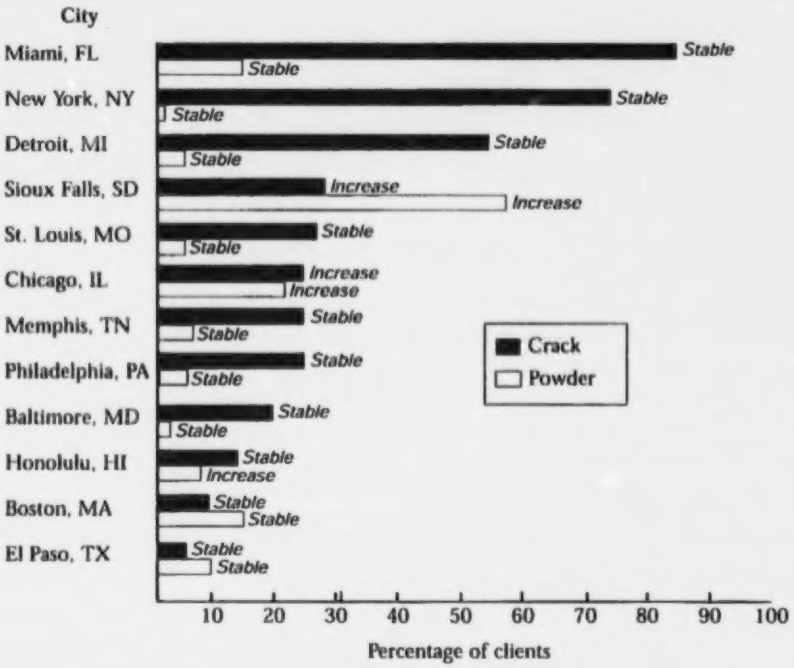
CRACK: USERS

How many crack users are in treatment? *(Exhibit 5)* Primary crack users constitute at least 10 percent of non-methadone treatment clients in 11 cities, with a high of 85 percent in Miami. Proportions of crack clients between fall 2001 and spring 2002 remained relatively stable in most cities, with several exceptions: increases are reported in five cities (Chicago[N], Columbia [SC][N], Memphis[E], St. Louis[M], and Sioux Falls[N]), and declines are reported in seven cities, mostly by epidemiologic sources (in Boston[E], Columbia[E], Denver[E,N], Honolulu[E], Miami[E], Philadelphia[E], and Portland [ME][N]). The epidemiologic source in Columbia states that the decrease in crack users may be related to users switching to other drugs, especially pharmaceutical opiates. The methadone treatment source in St. Louis reports that crack use as a secondary or tertiary drug has increased. Similarly, the methadone treatment source in Columbia reports that positive urinalyses for crack have increased. Drug users in that city often stay up all night using crack and visit methadone clinics the next morning for a "methadone crash."

Who uses crack? *(Exhibit 6)* The majority of epidemiologic/ethnographic and treatment sources report that crack users remain young adult (18–30 years), central city residents from low socioeconomic backgrounds. However, sources cite adolescents as the primary crack users in Billings[N] (along with young adults), Los Angeles[N] (along with young adults), and Sioux Falls[N]. Mean age of primary crack users ranges from 23 years in Boston to 39 years in Chicago.

Exhibit 5.
Which non-methadone treatment programs in *Pulse Check* cities have substantial percentages* of clients reporting crack or powder cocaine as their primary drug of abuse? How have those percentages changed (fall 2001 vs spring 2002)?**



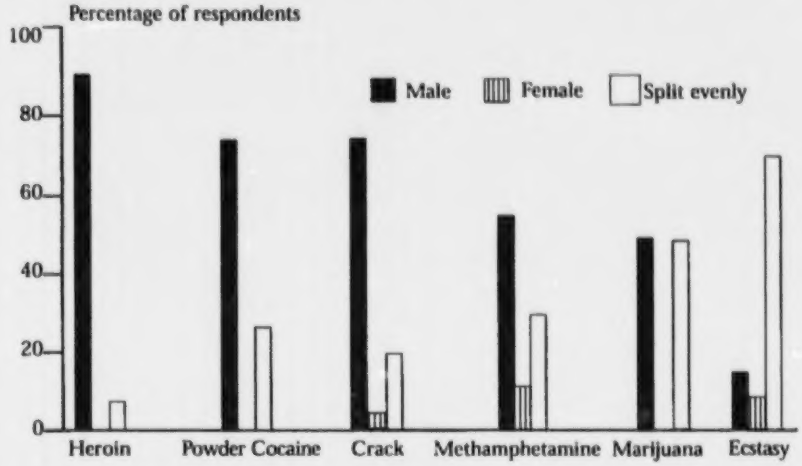
**10 percent or more for either crack or powder cocaine*
***Non-methadone treatment sources did not respond in Billings, Denver, Los Angeles, New Orleans, and Washington, DC.*

Crack users are predominantly male, according to 75 percent (15 of 20) of epidemiologic sources, although the gender gap is narrowing in several cities. For example, in Boston, Columbia (SC), Denver, Detroit, Los Angeles, and Seattle, about 40 percent of crack users are female. Blacks continue to be twice as likely as Whites to be reported as the predominant user group. Crack users in treatment tend to be court referred and unemployed. Slightly more than half have completed high school.

Overall, the number of crack users has remained relatively stable as a group since the last *Pulse Check* reporting period, with only a few changes in age, gender, race/ethnicity, and residence area, as noted on the following page.

How do users take crack cocaine? Nearly all epidemiologic/ethnographic and treatment respondents (48 of 52) report that crack users primarily smoke the drug. However, injecting is the primary route of administration according to methadone treatment sources in Columbia (SC) and Memphis; injecting and smoking are evenly split as routes of administration according to sources in Billings[N] and Seattle[E].

Exhibit 6. Which genders are the predominant users of specific drugs in the Pulse Check cities?



Source: Epidemiologic/ethnographic respondents

Except in Billings, where crack injection has increased since fall 2001, no changes in routes of crack administration are reported.

What other drugs do crack users take? Other drugs taken by crack users vary widely, with heroin and marijuana topping the list, and prescription drugs, such as benzodiazepines or pharmaceutical opiates, commonly reported:

- **Heroin taken in combination with crack ("speedball"):** Baltimore^{M}, Boston^{E}, Chicago^{E,M}, Columbia (SC)^{M}, Denver^{N}, Detroit^{M}, Honolulu^{N}, Miami^{E,M}, New Orleans^{E}, New York^{E,M}, Philadelphia^{E}, Portland (ME)^{N}, and Seattle^{E,M}
- **Marijuana taken in combination with crack in a blunt or joint, or sequentially to mitigate the crack effects:** Baltimore^{E}, Billings^{N}, Boston^{E}, Columbia^{E}, Denver^{E}, Detroit^{E,N}, El Paso^{E}, Honolulu^{E,N}, Los Angeles^{E,N}, Memphis^{E,N,M}, New York^{N}, New Orleans^{E}, Philadelphia^{E,N}, Portland^{E}, St. Louis^{E}, and Seattle^{N}
- **Benzodiazepines taken sequentially:** Boston^{E}, Memphis^{N,M}, Miami^{E}, Philadelphia^{N}, and Portland^{E}
- **Pharmaceutical opiates taken sequentially:** Baltimore^{M}, Memphis^{M}, Philadelphia^{N}, Portland^{N}, and Seattle^{M}

Other combinations include PCP with crack ("space basing") in New York, and methamphetamine in Honolulu. The non-methadone treatment source in Billings reports an increase in prescription drug use among crack users since the last reporting period.

The nature of crack users has changed only slightly (fall 2001 vs spring 2002)...

Users are aging in some cities, but younger users are reported in others:	➤ **Memphis, TN^{N}:** Even though young adults (18–30 years) predominate, crack users are aging.
	➤ **Miami, FL^{E}:** Predominant crack users are adults (>30 years) who continue to age.
	➤ **Billings, MT^{N}:** Adolescents and young adults predominate, but adolescents are increasingly using the drug.
	➤ **Los Angeles, CA^{E}:** Although adults predominate, younger users (late twenties) are increasing.
	➤ **Sioux Falls, SD^{N}:** Adolescents (13–18 years) predominate, but users are increasingly younger (<13 years).
Gender shifts are reported in only two cities:	➤ **Sioux Falls, SD^{N}:** Crack users used to be primarily males but are now evenly split between the genders.
	➤ **Washington, DC^{E}:** Young black females have been increasingly using crack.
Only one change is reported in race/ethnicity and geographic residence:	➤ **Sioux Falls, SD^{N}:** The predominant crack users are Whites and American Indians, but American Indians have increased since fall 2001. Similarly, both central city and rural areas predominate as residences, but crack use is becoming more common on American Indian reservations in rural areas.

Similarly, the non-methadone treatment source in Memphis notes an increase in sequential benzodiazepine use among crack users.

Where and with whom is crack used? As reported in past issues, crack generally tends to be used in private and in small groups or among friends, as reported by the majority of epidemiologic/ethnographic and treatment sources. It also continues to be used mostly in the streets, crack houses, private residences, and public housing developments. Other settings include homeless shelters, public restrooms, abandoned lots, and alleys in Boston; vacant lots and buildings in Philadelphia; and adult video stores in Honolulu. Sources report few changes since fall 2001: in Memphis, restaurants are a new use and sales setting for crack; in St. Louis, sales and use activity in parks has increased; and in Honolulu, use in public housing developments has declined due to policing.

POWDER COCAINE[+]

Three *Pulse Check* sources list powder cocaine as the drug contributing to the most serious consequences: in Boston[L], Denver[E], and El Paso[M]. One source in El Paso[N] names powder cocaine as the most widely used drug.

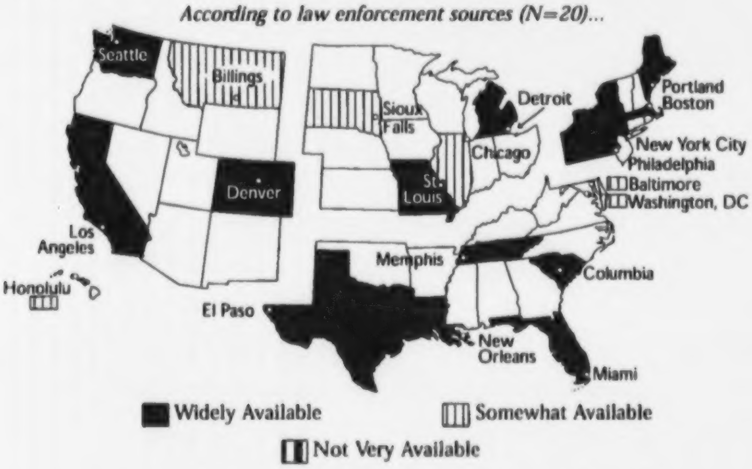
Compared with the last reporting period, only a few changes occurred: methamphetamine replaced powder cocaine as the drug contributing to the most serious consequences in Denver[L], and marijuana replaced powder cocaine in Seattle[N]. In El Paso[M], heroin replaced powder cocaine as the most widely used drug. In Miami[E], powder and crack cocaine replaced heroin as the drugs contributing to the most serious consquences—consequences propelled by the combination of these drugs with heroin or other opiates. Finally, in Sioux Falls[E,N], powder cocaine is emerging as a new drug problem in spring 2002.

POWDER COCAINE: THE DRUG

How available is powder cocaine across the country? *(Exhibits 1 and 2)* As reported in the past *Pulse Check*, more than half (23 of 40) of law enforcement and epidemiologic/ethnographic sources consider powder cocaine widely available in their communities, with no regional patterns. The remaining sources describe it as "somewhat available," with four exceptions: epidemiologic sources in

Exhibit 1.
How available is powder cocaine across the 20 *Pulse Check* cities (spring 2002)?

According to law enforcement sources (N=20)...


Seattle
Billings
Sioux Falls
Detroit
Portland
Boston
Chicago
New York City
Philadelphia
Baltimore
Washington, DC
Denver
St. Louis
Los Angeles
Memphis
Columbia
Honolulu
El Paso
New Orleans
Miami
Widely Available
Somewhat Available
Not Very Available

According to epidemiologists/ethnographers (N=20)...

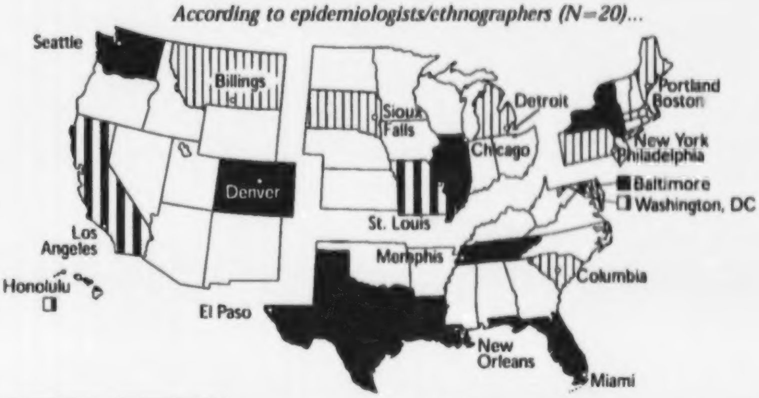

Seattle
Billings
Sioux Falls
Detroit
Portland
Boston
New York
Philadelphia
Chicago
Baltimore
Washington, DC
Denver
St. Louis
Los Angeles
Memphis
Columbia
Honolulu
El Paso
New Orleans
Miami

Exhibit 2.
How has powder cocaine availability changed (fall 2001 vs spring 2002)?

Memphis, TN[L]
New York, NY[E]
Portland, ME[L]
Sioux Falls, SD[E]

Baltimore, MD[L,E]
Billings, MT[L,E]
Boston, MA[L,E]
Chicago, IL[L,E]
Columbia, SC[L,E]
Denver, CO[L,E]
Detroit, MI[L,E]
El Paso, TX[L,E]
Honolulu, HI[L]
Los Angeles, CA[L,E]
Memphis, TN[E]
Miami, FL[L,E]
New Orleans, LA[L,E]
New York, NY[L]
Philadelphia, PA[E]
Portland, ME[E]
Seattle, WA[L,E]
Sioux Falls, SD[L]
St. Louis, MO[L,E]
Washington, DC[L,E]

Honolulu, HI[E]
Philadelphia, PA[L]

[+] *The following symbols appear throughout this chapter to indicate type of respondent: [L] Law enforcement respondent, [E] Epidemiologic/ethnographic respondent, [N] Non-methadone treatment respondent, and [M] Methadone treatment respondent.*

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Honolulu, Los Angeles, St. Louis, and Washington, DC, describe it as "not very available."

According to the majority of law enforcement and epidemiologic/ethnographic sources, powder cocaine availability remained stable between fall 2001 and spring 2002, with declines in two cities and increases in four.

What are powder cocaine prices and purity levels across the country? *(Exhibit 3)* Cocaine purity varies widely across *Pulse Check* cities: from 40 to 80 percent in the Northeast and from 50 to 90 percent in the West. Only one source each in the South and Midwest report purity, and no changes in purity levels are reported since fall 2001. New powder cocaine adulterants are reported only in Memphis: the epidemiologic source reports quinine as a new adulterant this reporting period, and the law enforcement source in that city reports traces of heroin in crack and powder cocaine (as reported in the *Crack Cocaine* section).

Prices also vary widely across *Pulse Check* cities, with most gram prices hovering around $100. Since the last *Pulse Check*, prices declined slightly in Boston and Los Angeles.

How is powder cocaine referred to and packaged across the country? *(Exhibit 4)* In all U.S. regions powder cocaine remains known as "blow," "coke," or "powder," but other slang terms often vary by region. Sources report few new names in spring 2002, including "aspirin" in the South and "snort" in the Midwest. In Boston, when dealers discuss sales over cell phones, they use feminine names, such as "girl" or "sister," as code words to disguise the topic of their conversations.

Like heroin and crack, street-level powder cocaine is most commonly packaged in plastic, cellophane, glassine, and zipper bags. It is also commonly folded in paper ("pony packs," "papers," "triple folds," "diamond folds," "whites," and "bindles"), as reported in Denver, Detroit, El Paso, Los Angeles, Memphis, Portland (ME), St. Louis, and Seattle. Other less common packaging includes aluminum foil and dollar bills in New York, capsules in Baltimore, cigarette packs and vials in Memphis, aluminum foil in New Orleans, balloons in El Paso, and plastic bags with logos to indicate dealers in Miami—the only city where labeling is mentioned this reporting period. Law enforcement and epidemiologic/ethnographic respondents report no changes in packaging since fall 2001.

Exhibit 3.
What are the prices and purity levels of powder cocaine in 18 *Pulse Check* cities?*

	City/Source	Gram purity	Gram price
Northeast	Boston, MA^{E}	NR	$50
	Boston, MA^{L}	50–60%	$60
	New York, NY^{L}	75%	$28–$30
	Philadelphia, PA^{L}	60–80%	$120–$125
	Portland, ME^{L,E}	40–60%	$80–$100
South	Baltimore, MD^{L}	NR	$90–$100
	Columbia, SC^{L}	NR	$100
	Memphis, TN^{E}	NR	$45–$100
	New Orleans, LA^{E}	NR	$80–$150
	Washington, DC^{E}	NR	$50–$100
	Washington, DC^{L}	30–60%	$100
Midwest	Chicago, IL^{E}	NR	$50–$100
	Chicago, IL^{L}	NR	$125
	Detroit, MI^{L,E}	NR	$75–$125
	St. Louis, MO^{E}	77%	$100–$125
	Sioux Falls, SD^{L}	NR	$100
West	Billings, MT^{L}	50–70%	$100
	Denver, CO^{L,E}	30–90%	$100–$125
	Honolulu, HI^{L,E}	NR	$100–$125
	Los Angeles, CA^{L}	80%	$100
	Seattle, WA^{E}	57–68%	$35–$50
	Seattle, WA^{L}	57–68%	$80–$100

**Sources in El Paso and Miami did not provide this information.*
NR=Not reported

POWDER COCAINE: THE MARKET

Who sells street-level powder cocaine? Law enforcement and epidemiologic/ethnographic sources identify powder cocaine sellers as independent twice as often as they identify them as organized. In many cities (Boston^{E}, Chicago^{L}, El Paso^{L}, Los Angeles^{L}, Memphis^{E}, Philadelphia^{L}, and Portland [ME]^{L}) independent and organized structures are equally common. In Seattle^{L} two types of powder cocaine sellers exist: "go-betweens" who are addicts and serve as liaisons between buyers and "the guy in the car," who supplies the drug and does

Exhibit 4.
How is powder cocaine referred to in the four regions of the country?*

WEST

Blow, coke, dust, fast, flake, nose candy, powder, sniff, snow, sugar, white, white boy, white lady, yao

Coke, flake

MIDWEST

Blow, coke, girl, powder, shirt, SNORT, white

NORTHEAST

Blow, coke, flake, flave, girl, lady, nose candy, product, aunt, cola, perico, powder, sister, snow, snow birds, white, big C, devil's dandruff, uptown

Blow, coca, coke, girl, lady, she, powder, shake, shrile, snow, soft, toot, white, blanca, white girl, white horse, white lady, white man, white pants, snow white, ASPIRIN, bird, candy, DP (dime pack), eightball, a half (half gram), perico, p-packs, sal (salt), sugar

SOUTH

**Names in all caps are new this reporting period.*
Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

not typically use it. As reported in past *Pulse Checks*, young adults (18–30 years) are almost exclusively the sellers of the drug, with few exceptions. Adolescents and young adults sell powder cocaine in Chicago[E] and Los Angeles[L,E]; adults (>30 years) and young adults sell the drug in Boston[L], Chicago[L], El Paso[L], and Portland[L]; and adults sell it in El Paso[E]. Only one change in seller characteristics is noted since the last reporting period: in Portland[L], powder cocaine sellers are increasingly organized and are selling greater quantities of the drug.

Similar to percentages for heroin and crack cocaine, according to law enforcement and epidemiologic/ethnographic sources, powder cocaine sellers often use the drug: about one-third report them as very likely to use the drug, and about half (a much higher percentage than for heroin at 30 percent or crack at 31 percent) report them as somewhat likely to use the drug (*see Highlights Exhibit 8*).

What other drugs do powder cocaine dealers sell? More often than not, law enforcement and epidemiologic respondents report that powder cocaine dealers sell other drugs, with 10 of 27 respondents reporting no other drugs sold by powder cocaine dealers. The most common other drug sold is marijuana, followed by crack, heroin, and methamphetamine. In Columbia (SC)[L] crack and marijuana are sold by powder cocaine dealers in the streets, but ecstasy is sold by powder cocaine dealers in nightclubs. Sources report no changes in other drugs sold since the last reporting period.

What types of crimes are related to powder cocaine sales? Powder cocaine dealers are often involved in violent crimes, such as assaults in New York, robbery and theft in Memphis, home invasions in Miami, and street robberies in Los Angeles. Nonviolent crimes include auto thefts, break-ins, and larceny in Columbia (SC); burglaries in El Paso, Los Angeles, and Billings; transporting illegal aliens in El Paso; and money laundering in Miami. Law enforcement and epidemiologic/ethnographic sources also mention domestic violence and prostitution as crimes in which powder cocaine sellers are often involved.

Where are powder cocaine markets located? Unlike heroin and crack cocaine sales, which are conducted primarily in central city areas, powder cocaine sales are more evenly distributed among geographic areas. For example, law enforcement and epidemiologic/ethnographic sources in nine cities list all areas (central city, rural, and suburban) as locations equally likely to have powder cocaine markets. Similarly, both indoor and outdoor sales are equally common, according to sources in the majority of cities (13 of 20). Similar to crack sales settings, streets, private residences, and public housing developments are the oft-mentioned powder cocaine settings. Unlike crack sales settings, nightclubs and bars are often mentioned as powder cocaine settings (by 17 of 20 law enforcement sources), as are raves and concerts (by 8 of 20 law enforcement sources).

Several new powder cocaine sales settings are reported (fall 2001 vs spring 2002)...

- **Miami, FL[L]**: The Internet is now used as a communication tool for powder cocaine sales.
- **New Orleans, LA[E]**: Sales locations have expanded to include settings other than public housing projects.
- **Philadelphia, PA[L]**: Sales have moved indoors.
- **Portland, ME[E]**: Settings now include private parties and hotel or motels.

POWDER COCAINE: USERS

How many powder cocaine users are in treatment? ***(Exhibit 5)*** Primary powder cocaine users constitute 10 percent or more of treatment clients in five cities (Boston, Chicago, El Paso, Miami, and Sioux Falls), compared with 11 cities for crack clients *(see Crack Exhibit 5).* The largest proportion, by far, of powder cocaine clients is in Sioux Falls at 58 percent. Between fall 2001 and spring 2002, proportions of powder cocaine users remained relatively stable among treatment clients in most cities, with several exceptions: increases are reported in six cities, and declines are reported in three, as shown in the arrows below.

Exhibit 5.
How has the number of powder cocaine users changed (fall 2001 vs spring 2002)?

Chicago, IL^{N}
Columbia, SC^{N}
Denver, CO^{E}
Honolulu, HI^{M}
Miami, FL^{E}
Sioux Falls, SD^{E,N}

Columbia, SC^{E}
Denver, CO^{N,M}
Portland, ME^{N}

Who uses powder cocaine? Powder cocaine users are predominantly adult (>30 years) White males, who live in central city areas. Although most epidemiologic/ethnographic and treatment sources agree that powder cocaine users are predominantly adults, variations are reported: 14 of 45 respondents report young adults (18–30 years) as the predominant powder cocaine users, 3 report adolescents (13–18 years) and young adults as the predominant age groups, and 2 report adolescents as the predominant group. Similarly, although males are most often reported as the predominant gender of powder cocaine users (by 26 of 45 respondents), 17 respondents report that the genders are evenly split, and 2 report that females predominate. Most respondents (21 of 45) report Whites as predominant users, but Blacks predominate according to 11 respondents, Hispanics predominate according to 4 respondents (in El Paso, Los Angeles, and New York), and Blacks and Hispanics predominate according to the non-methadone sources in Miami and New York.

Few changes are reported in user characteristics for powder cocaine (fall 2001 vs spring 2002)...

Age distribution changes:	➤ **Billings, MT^{N}**: The number of young adult (18–30 years) users increased slightly. ➤ **Sioux Falls, SD^{E,N}**: The epidemiologic/ethnographic source reports that the new group of powder cocaine users is increasingly younger. The non-methadone treatment source adds that preadolescents and adolescents have increased since the last reporting period.
Gender distribution changes:	➤ **Columbia, SC^{N}**: Female use is increasing. ➤ **Memphis, TN^{E}**: Male use is increasing
Race/ethnicity distribution changes:	➤ **Denver, CO^{E}**; **Miami, FL^{M}**; **and Sioux Falls, SD^{E}**: Hispanics increased as powder cocaine users (especially younger Hispanics in Miami).

How do users take powder cocaine, and what other drugs do they take? Snorting remains the most common administration route. However, seven respondents (mostly methadone treatment sources who identify powder cocaine as used in combination with heroin) list injecting as the primary route of administration. Several epidemiologic/ethnographic and treatment respondents list a variety of routes as common: snorting and injecting are equally common in Billings^{N} and El Paso^{M}; snorting and smoking are equally common in Boston^{E} and Miami^{M}; and snorting, smoking, and injecting are equally common in Sioux Falls^{N}.

Heroin taken in combination with powder cocaine as a "speedball" remains common in many cities across the Nation (particularly among methadone treatment clients), including Baltimore^{E}, Boston^{E,M}, Chicago^{E,M,N}, Denver^{E,N}, El Paso^{M}, Los Angeles^{M}, Memphis^{E}, Miami^{E,M}, New York^{E,M}, Philadelphia^{E}, Portland (ME)^{E}, St. Louis^{M}, Seattle^{M}, and Washington, DC^{E}.

Marijuana also remains commonly taken with powder cocaine, either in combination as a cocaine-laced blunt or joint ("primo"or "tio" in El Paso, "cocoa puff" in Honolulu, and "primo" or "p-dog" in Los Angeles) or sequentially.

Prescription drugs, such as benzodiazepines or opioids, continue to be used in combination or sequentially with powder cocaine in several cities: Boston, Memphis (alprazolam [Xanax®] or hydromorphone [Dilaudid®]), New York, Philadelphia, Portland, and St. Louis (diazepam).

Sources identify several changes in the route of powder cocaine use (fall 2001 vs spring 2002)...

- **El Paso, TX[M]**: Powder cocaine users increasingly mix snorting and injecting as their preferred route of administration.
- **Seattle, WA[E]**: Anal use of the drug is a new phenomenon.
- **Sioux Falls, SD[N]**: Injecting the drug has increased.

Club drugs, such as ecstasy, are used in combination or sequentially with powder cocaine in Miami (to "bump up"), Portland (ME), and Seattle.

Where is powder cocaine used? As reported in previous *Pulse Checks*, powder cocaine tends to be used indoors, in private, and in small groups among friends. Private residences are the most common use settings, followed by private parties, nightclubs and bars, cars, and streets.

No changes are reported since fall 2001, but unusual use settings include boats in Portland (ME) and parking lots around supermarkets, strip malls, and convenience stores (for sales and use) in Miami.

From powder to crack...

- **Memphis, TN[N]**: Powder cocaine users tend to start out with powder cocaine in their youth. They then advance to crack in adulthood.

MARIJUANA*

Honolulu, Memphis, and New Orleans are the only three cities where no *Pulse Check* source names marijuana as their community's most widely abused drug *(see Highlights Exhibit 3)*. In the other 17 *Pulse Check* cities, 34 law enforcement, epidemiologic/ethnographic, and non-methadone sources name marijuana as such. Additionally, three non-methadone sources—in Columbia (SC), Seattle, and Sioux Falls—consider marijuana the drug that contributes to the most serious consequences. Compared with the last *Pulse Check* reporting period, the Seattle non-methadone treatment source believes that marijuana has replaced cocaine as the drug contributing to the most serious consequences, and the law enforcement source in Washington, DC, believes it has replaced crack as the most widely used drug.

MARIJUANA: THE DRUG

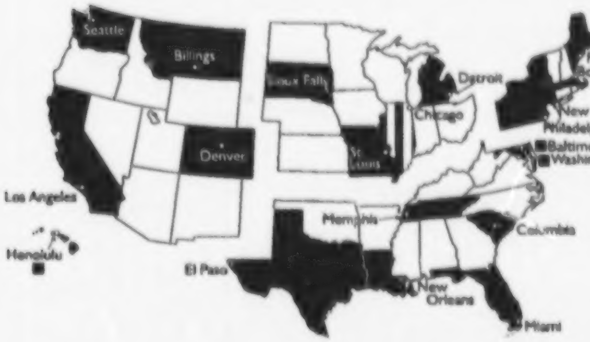
How available is marijuana, in its various forms, across the country? *(Exhibits 1, 2, and 3)* As reported in the last several *Pulse Checks*, all but 1 of the 40 law enforcement and epidemiologic/ethnographic sources consider marijuana widely available in their communities. The exception continues to be in Chicago, where the law enforcement source considers the drug somewhat available.

The two most common varieties of marijuana are local commercial grade and Mexican commercial grade. The former is ranked as widely available by 23 sources in all but 4 of the *Pulse Check* cities (Boston, Chicago, Detroit, and El Paso); the latter is ranked as such by 21 sources in all but 3 cities (Miami, Portland [ME], and Washington, DC)—an increase since the last *Pulse Check*.

Sinsemilla (seedless marijuana) remains the third most common variety (ranked widely available by 16 sources in 12 cities), followed by hydroponically grown marijuana (ranked widely available by 12 sources in 9 cities). British Columbian marijuana ("BC bud") remains the least common variety, with only six sources ranking it as widely available

Exhibit 1.
How available is marijuana across the 20 Pulse Check cities (spring 2002)?

According to law enforcement and epidemiologic/ethnographic sources (N=40)...



■ Widely Available, according to both source types
☐ Widely Available, according to the epidemiologic/ethnographic source; somewhat available according to the law enforcement source

Exhibit 2.
How has marijuana availability changed (fall 2001 vs spring 2002)?

Boston, MA^{E}
Denver, CO^{L}

Baltimore, MD^{L,E}
Billings, MT^{L,E}
Boston, MA^{L}
Chicago, IL^{L,E}
Columbia, SC^{L,E}
Denver, CO^{E}
Detroit, MI^{L,E}
El Paso, TX^{L,E}
Honolulu, HI^{L,E}
Los Angeles, CA^{L,E}
Memphis, TN^{L,E}
Miami, FL^{L,E}
New Orleans, LA^{L,E}
New York, NY^{L,E}
Philadelphia, PA^{E}
Portland, ME^{L,E}
Seattle, WA^{L,E}
Sioux Falls, SD^{L,E}
St. Louis, MO^{L,E}
Washington, DC^{L,E}

Philadelphia, PA^{L}

**The following symbols appear throughout this chapter to indicate type of respondent: ^{L}Law enforcement respondent, ^{E}Epidemiologic/ethnographic respondent, ^{N}Non-methadone treatment respondent, and ^{M}Methadone treatment respondent.*

BEST COPY AVAILABLE

Exhibit 3.
Which marijuana varieties have changed in availability (fall 2001 vs spring 2002)?

Hydroponic
Boston, MA^{L,E}
Columbia, SC^{L}
Denver, CO^{L}
Memphis, TN^{L}
Miami, FL^{E}
New York, NY^{E}
Seattle, WA^{L}

BC bud
Billings, MT^{L}
Boston, MA^{E}
Denver, CO^{L}
Los Angeles, CA^{E}
Seattle, WA^{L}

Local commercial grade
Boston, MA^{E}
Denver, CO^{L}

Sinsemilla
Boston, MA^{E}

Mexican
Denver, CO^{L}

Hydroponic
St. Louis, MO^{E}

Local commercial grade
Philadephia, PA^{L}

Mexican
Philadephia, PA^{L}
Seattle, WA^{L}

in four cities: Baltimore, Billings, New York, and Seattle.

Since the last reporting period, availability of marijuana in general has remained stable, with only two perceived increases and one perceived decline, as shown in the first arrows. Similarly, the numerous varieties have remained generally stable in availability, although a few shifts are noted (in the second arrows), particularly increases in hydroponic marijuana and BC bud. The latter variety has increased mostly in the West.

How is domestic marijuana grown? Indoor and outdoor growing operations ("grows") are reported about equally:

- **Indoors**: Billings^{L}, Boston^{L}, Denver^{L}, Memphis^{L}, Miami^{L,E}, New Orleans^{E}, New York^{L}, Philadelphia^{L}, St. Louis^{L}, and Seattle^{L,E}
- **Outdoors**: Baltimore^{L}, Honolulu^{L}, Los Angeles^{L}, Memphis^{E}, New Orleans^{L}, St. Louis^{E}, Sioux Falls^{L,E}, and Washington, DC^{L}
- **Both**: Chicago^{L}, Denver^{L}, Detroit^{L,E}, Honolulu^{E}, New York^{E}, Portland^{L,E}, and Washington, DC^{E}

A few shifts are reported since the last *Pulse Check*:

- **Boston, MA^{L}**: Increases are noted in the number of indoor hydroponic grows, the amount grown, and THC levels. Most marijuana, however, continues to come from Canada via Hell's Angels.
- **Denver, CO^{L}**: While most marijuana is grown locally indoors, bigger loads have been coming in from Mexico.
- **Miami, FL^{L}**: Indoor grows continue to be popular, sometimes in gated communities, sometimes in houses rented specifically for growing. Since the last reporting period, Cuban refugees have become increasingly involved in marijuana grow houses.
- **Philadelphia, PA^{L}**: While local indoor grows are still not common, they are increasing.
- **Portland, ME^{L}**: Marijuana growing continues to become more sophisticated, with new seedlings moved indoors for the winter and then moved outdoors again in the spring.
- **Sioux Falls, SC^{E}**: Outdoor grows are influenced by weather and seasonal changes.
- **Washington, DC^{L}**: Hidden outdoor grows are increasing.

Have street-level prices and adulteration changed across the country? *(Exhibit 4)* Prices and purity levels have remained generally stable since the last reporting period, with a few exceptions. Five shifts involve increases:

- **Billings, MT^{L}**: The gram price has increased slightly from $5 to $10–$20, depending on quality
- **Boston, MA^{L}**: Marijuana continues to increase in potency and price.
- **Miami, FL^{L}**: Pound prices have increased from $4,000 to $5,000.
- **New York, NY^{E}**: Purity has increased.
- **Portland, ME^{E}**: Both purity and prices have increased.

Three shifts involve declines:

- **Chicago, IL^{E}**: Prices have declined at the lower end of the range.
- **El Paso, TX^{L}**: Pound prices have declined from $445–$300 to $275–$300.
- **Honolulu, HI^{E}**: Pound prices have declined considerably.

Only a few THC levels are reported: 15–22 percent per gram of sinsemilla in Honolulu; 4–6 percent for Mexican grade and 25 percent per mid-grade ounce in Los Angeles; and 2–3 percent per pound of Mexican, 12–18 percent per pound of domestic indoor hydroponic, and 15–25 percent per pound of BC bud in Seattle. Marijuana is sometimes sold with adulterants, with a few instances reported this period:

- **Columbia, SC^{N,M}**: Marijuana is laced with crack, PCP ("chronic"), or "embalming fluid ("wet joints"). PCP-laced joints are increasing.
- **Miami, FL^{M}**: Some dealers lace marijuana with cocaine to get customers to return. The buyers assume "it's just especially potent marijuana."
- **Washington, DC^{M}**: Adulterants include embalming fluid and baby oil.

Have marijuana slang terms changed across the country? *(Exhibit 5)* Among the many slang terms for marijuana, marijuana smoking, and marijuana combinations, only a few are new: "chronic" in Chicago; "schwagg" and "spliff" in Memphis; and "crank" in Washington, DC.

MARIJUANA: THE MARKET

Who sells marijuana? As reported in past *Pulse Checks*, marijuana sellers are more likely to operate independently than as part of organized operations. However, organizations with varying degrees of structure do exist in several cities, such as Memphis, Miami, and New Orleans in the South, Chicago and Detroit in the Midwest, and Billings in the West.

The vast majority of *Pulse Check* law enforcement and epidemiologic/ethnographic sources continue to report that marijuana sellers are somewhat or very likely to use their

Exhibit 4. How much does marijuana cost in 19 *Pulse Check* cities?*

		MOST COMMON STREET UNIT			1 OUNCE
	City/Source	Type	Unit	Price	Price
Northeast	Boston, MA^{E}	Commercial	0.125 oz	$20	$100–$125
			0.33 oz bag	$50	NR
	Boston, MA^{L}	Sinsemilla			$80–$100
	New York, NY^{E}	Commercial	bag	$10	NR
		Hydroponic	bag	$20	NR
	New York, NY^{L}	Commercial			$100–$200
		Hydroponic or sinsemilla			$300–$1,200
	Philadelphia, PA^{E}	NR	bag, blunt	$5	NR
	Philadelphia, PA^{L}	Commercial			$150–$200
	Portland, ME^{L}	NR	joint	$5	$175–$225
South	Baltimore, MD^{L}	NR	joint	$1–$3	$100
	Columbia, SC^{L}	Mexican or local commercial	dime bag, 3–4 g	$10	$180
	El Paso, TX^{E}	NR	bag, five joints	$20	NR
	El Paso, TX^{L}	Mexican commercial	0.25 oz	$20	NR
	Memphis, TN^{E}	Commercial	joint	$5	$100
			quarter bag	$25	NR
	Memphis, TN^{L}	NR	0.25 oz	$25	$100
	New Orleans, LA^{E}	NR	joint	$7	NR
	New Orleans, LA^{L}	NR	joint	$5	$300
	Washington, DC^{E}	Commercial	bag, several joints	$5–$10	$100
			blunt	$10–$20	
		Hydroponic	NR	NR	$480
	Washington, DC^{L}	NR	20–bags	$20	NR
Midwest	Chicago, IL^{E}	NR	loose bag	$5–$10	$80–$200
	Detroit, MI^{E}	NR	0.25 oz	$200	NR
			one joint	$2–$6	
	Detroit, MI^{L}	NR	bag, 1 g	$10	NR
	St. Louis, MO^{L}	NR	small bag	$20	$100
	Sioux Falls, SD^{L}	Mexican commercial			$100–$200
		BC bud			$400
West	Billings, MT^{L}	NR	1 g	$10–$20	NR
	Denver, CO^{L}	NR	NR	NR	$100–$200
	Denver, CO^{E}	BC bud	NR	NR	$600
	Honolulu, HI^{E}	NR	joint	$5–$20	NR
			1 g	$25	NR
	Honolulu, HI^{L}	Sinsemilla	1 g	$25	NR
	Los Angeles, CA^{E}	Mexican commercial	1 g	$10	$60–$80
		Mexican mid grade	1 g	$25	$200–$250
	Los Angeles, CA^{L}	Mexican	dime bag, 1 g	$10	NR
	Seattle, WA^{E}	NR	1 g	$10–$20	$400

**Respondents in Miami did not provide this information.*
NR = not reported
Sources: Law enforcement and epidemiologic/ethnographic respondents

Exhibit 5.
How is marijuana referred to in the four regions of the country?*

WEST	MIDWEST	NORTHEAST
Bud, grass, herb, mary jane, pot, smoke, weed, babysitter, chemo, colas, firewood, pakaloco, (crazy tobacco), salad, skunk, **chronic** (bc bud), crip, triple a (bc bud), kind bud (high quality), ragweed, skunkweed, swag (low quality), kona gold, kawaii electric, maui wowie	Bud, grass, green, mary jane, pot, reefer, smoke, weed, blunts, chronic, nickel bags ($5 bags), LG (lime green), hydro, chiefing (smoking marijuana)	Bud, doobie, dope, pot, ganja, grass, herb, jay, mary jane, reefer, smoke, trees, weed, arizona, blunt, bone, chronic, gorge, hash, hash oil, homegrown, hydro, joint, loose shank, purple haze, roach, scrub, sinse or sins (sinsemilla), vermont, blazing (smoking marijuana)

SOUTH

Bud, doobie, dope, fire, herb, ganja, grass, green, jane, mary jane, pot, smoke, trees, weed, blow, bush, clover, **crank**, dip, mota, salad, **schwagg**, red bud (hydroponic), bubbleberry (hydroponic), gold bud, hydro, teak (hydroponic), ink (hydroponic), kryptonite or krippy (high-grade hydroponic), ragweed (low grade), ditchweed (low grade), kindbud, THC, chronic (PCP laced), wet joints (embalming fluid laced), macaroni, macaroni and cheese ($10 of cocaine and $5 pack of marijuana), blunt, **spliff**, baggies

** Bolded names are new this reporting period.*
Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

own drug, much more so than sellers of other drugs *(see Highlights Exhibit 8)*. The majority of sources also continue to report young adults (18–30 years) as the predominant sellers. Adolescents, however, are named as such in Baltimore^{E} and New Orleans^{L}. Both adolescents and young adults are named by some sources (as in Billings^{L}, Chicago^{E}, Honolulu^{E}, Los Angeles^{L,E}, Memphis^{E}, and New Orleans^{E}), while both young adults and adults older than 30 are named by others (in Boston^{L}, El Paso^{L}, St. Louis^{L,E}, and Sioux Falls^{L}). All three age groups are named in Baltimore^{L}. Since the last *Pulse Check*, adolescent sellers have been increasing in Memphis^{E}.

What types of crimes are related to marijuana sales? Marijuana sellers are more likely to be involved in nonviolent crimes, such as theft, robbery, and burglary, than in violent crimes. The drug is seldom associated with rape, domestic violence, or prostitution *(see Highlights Exhibit 7)*. When violent crime is reported, it is sometimes associated with organized rather than independent dealers, as in St. Louis. In Sioux Falls, any violent crime involving marijuana sales typically also involves methamphetamine. One change for the worse is reported since the last *Pulse Check*: in Memphis, marijuana sales have been increasingly associated with gang-related violent crimes, such as murders and shootings.

How and where do marijuana markets operate? Marijuana sales often involve acquaintance or referral networks, posing a challenge to law enforcement disruption efforts. The actual exchanges are usually hand-to-hand, sometimes at prearranged meetings (as in Chicago, Columbia [SC], Honolulu, Memphis, and Washington, DC) or via home delivery (as in Boston, El Paso, Portland [ME], and Seattle). Beepers and cell phones are sometimes involved (as in Boston, Honolulu, Los Angeles, Memphis, New Orleans, Seattle, and Sioux Falls). Open-air markets still exist in some cities (such as Chicago, Honolulu, New Orleans, Philadelphia, Seattle, and Washington, DC), although sometimes they are held in more discreet areas of public housing developments (as in Chicago, New Orleans, and Washington, DC).

As reported in past *Pulse Checks*, marijuana, more than other drugs, tends to be sold both indoors and outdoors and in all types of geographic areas—central city, suburban, and rural. The specific market settings remain varied, with only a handful of changes since the last *Pulse Check*:

- **Boston, MA^{L}**: Sales continue to move more underground than in the past, with an increasing use of beepers.
- **Detroit, MI^{L}**: Sales have increased in sheer volume.
- **Memphis, TN^{E}**: More outdoor sales are reported, but the number of sales settings has declined. Sales around stores or treatment clinics, reported in the past, are not reported during this period.
- **New Orleans, LA^{E}**: The marijuana market, once limited to public housing projects, has spread to all parts of the city.
- **Philadelphia, PA^{L}**: Operation Safe Streets has generated much market movement, both indoors and to other street corners. This movement has had two effects: when markets move indoors, law enforcement can target specific homes; and out-of-town buyers have become particularly confused when they see the visible police presence, and they do not know where to "score."

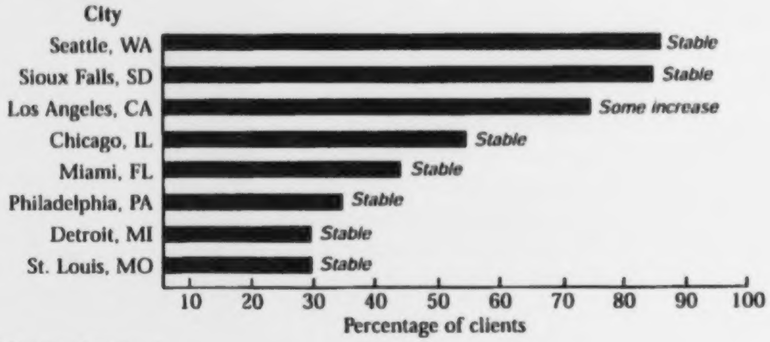
What other drugs are associated with marijuana sales? About half of reporting law enforcement and epidemiologic/ethnographic sources report that marijuana dealers sell no other drugs. In St. Louis, the gang-related distributors sell other drugs, while the independent low-level dealers do not. Conversely, in Sioux Falls, larger marijuana dealers sell only marijuana, while other dealers sell crack or methamphetamine as well. In Chicago, heroin and cocaine are sometimes sold on the same streets as marijuana, but not by the same people. The drugs most commonly reported as sold by marijuana dealers, in descending order of frequency, are as follows:

- **Crack**: Columbia (SC)^{L}, Denver^{E}, Honolulu^{L}, New Orleans^{L,E}, New York^{L}, St. Louis^{E}, and Sioux Falls^{L}
- **Powder cocaine**: Columbia^{L}, Denver^{E}, Honolulu^{L}, Memphis^{L}, Miami^{L}, and New York^{L}
- **Heroin**: Baltimore^{L}, Denver^{E}, New Orleans^{L}, New York^{L}, and St. Louis^{E}
- **Ecstasy**: Denver^{L}, Honolulu^{L}, Miami^{L,E}, and New York^{L}
- **Methamphetamine**: Billings^{L}, Denver^{L,E}, Honolulu^{L}, and Sioux Falls^{L}
- **Flunitrazepam (Rohypnol®, or "roches")**: El Paso^{E}

MARIJUANA: THE USERS

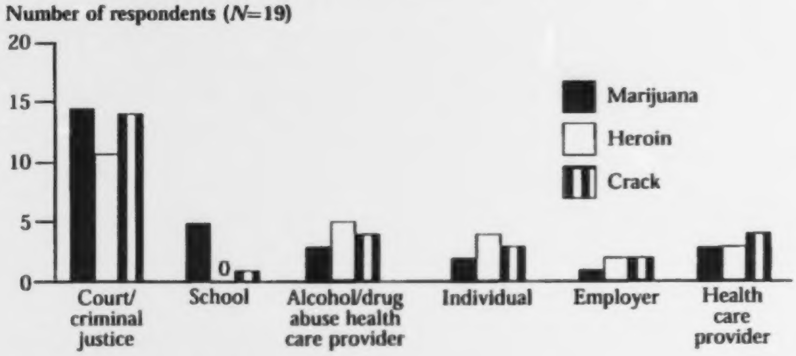
How many marijuana users are in treatment, and how do they get there? ***(Exhibits 6 and 7)*** Marijuana use by clients in treatment has remained relatively stable in most *Pulse Check* cities since the last reporting period. The drug accounts for sizable proportions of clients in treatment at non-methadone programs represented by several *Pulse Check* sources, as shown in the graph. Furthermore, these percentages are even higher when including all use, whether primary, secondary, or tertiary. For example, 100 percent of the clients in the Seattle and Sioux Falls programs report any marijuana use. In methadone programs, virtually all marijuana use is secondary or tertiary.

Exhibit 6.
Which non-methadone treatment programs in *Pulse Check* sites have substantial percentages* of clients reporting marijuana as their primary drug of abuse? How have those percentages changed (fall 2001 vs spring 2002)?



**30 percent or more*

Exhibit 7.
How are different drug users referred to treatment?



Sources: Non-methadone treatment respondents
Note: Many respondents list more than one referral source.

Marijuana users are predominantly referred to treatment through courts or the criminal justice system, more so than users of other drugs, as reported in past *Pulse Checks*. School referrals to treatment are also more likely among marijuana users than among users of other drugs. Referral sources have remained generally stable since the last reporting period, with three exceptions:

- **New York, NY**^{M}: More people are being referred through the parole system.

- **Portland, ME[N]**: Referrals from other health providers have been increasing.
- **Sioux Falls, SD[N]**: More self-referrals and family referrals are reported.

Who uses marijuana? *(Exhibits 8 and 9)* While young or older adults are most frequently reported as the predominant marijuana-using group, several sources report adolescents as such: Baltimore[E], Chicago[N], Columbia (SC)[M,N], El Paso[E,N], Denver[E], Los Angeles[E], and New Orleans[E]. An additional 11 sources report adolescents along with one or both older age groups as the predominant group. Moreover, one source in Sioux Falls[N], reports adolescents along with preadolescents (<13 years).

As the table shows, the differences between the populations described by epidemiologic/ethnographic, non-methadone treatment, and methadone treatment sources are particularly apparent with regard to marijuana. Marijuana users also differ in many ways from users of other drugs. For example, as the graph shows, they are more likely to reside in all locations (central city, suburban, and rural areas), rather than be concentrated in just one or two areas.

How do users take marijuana? Joints remain the most common vehicle for smoking marijuana, as reported in past *Pulse Checks*. However, blunts (hollowed-out cigars filled with marijuana) are more common than joints in many cities, such as Baltimore[N], Chicago[N], Columbia (SC)[N], Memphis[N], New Orleans[E], New York[E], and Philadelphia[E,N]. Other, less commonly reported delivery systems include pipes (in Columbia[N], Denver[E], Los Angeles[N], Memphis[E], and Sioux Falls[E]), bongs (in Denver[E], Honolulu[N], Los Angeles[E], and Seattle[N]), and bowls (in Columbia[N] and Los Angeles[E]). Wraps, made of either tobacco leaves or colored or flavored papers, are a more recently reported vehicle for smoking marijuana (in El Paso[E], Miami[M], Philadelphia[E], and Washington, DC[E]).

A few shifts are noted since the last report:

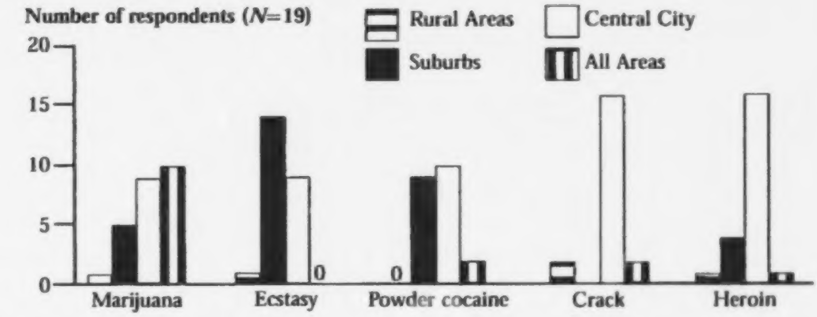
- **Boston, MA[N]**: Blunts are becoming more common.
- **Boston, MA[E]**: Blunt wraps are increasing, while there is a movement away from paper.
- **El Paso, TX[E]**: Use in joints has been declining as colored and flavored papers are becoming more common.
- **Memphis, TN[N]**: Blunts have been increasingly used for the past 5 years. They have now become more common than joints.

Exhibit 8.
Who is most likely to use marijuana?

Different source groups deal with quite different populations. Thus, each group paints a slightly different picture of the kind of people most likely to use marijuana...

Predominant user characteristic	Epidemiologic/ ethnographic sources tend to report...	Non-methadone treatment sources tend to report...	Methadone treatment sources tend to report...
Age	Cuts across all groups	Young adults	Older adults
Average mean age	22.25 (*n*=11)	22.85 (*n*=7)	35.8 (*n*=6)
Gender	Half report males; half report even gender splits	Males (but 7 report equal gender splits)	Males (only 3 report equal gender splits)
Race/ethnicity	Varies widely	Varies widely	Varies widely
Socioeconomic status	Cuts across all groups	Low	Low
Residence	Cuts across all areas	Central city	Central city
Education (highest level completed)	NR	Junior high and high school equally likely	High school
Employment	NR	Student or unemployed	Unemployed

Exhibit 9.
Where are drug users most likely to reside?



Sources: Epidemiologic/ethnographic respondents *Note: Some respondents list two areas per city*

The nature of marijuana users is changing in some cities (fall 2001 vs spring 2002)...

Since the last reporting period, no changes are reported in socioeconomic status or place of residence. A few shifts are reported, however, in age, gender, race/ethnicity, and employment status.

Several age shifts reflect a decline in the age of marijuana users:	➤ **Boston, MA^{N}**: While this specific program is only for people older than 18, other programs are showing an increase in adolescent users. ➤ **Columbia, SC^{E}**: An increasingly younger population was seen last reporting period, and this trend has continued. ➤ **Honolulu, HI^{E}**: The number of young adult users in treatment is increasing. ➤ **Los Angeles, CA^{N}**: The number of younger users is increasing. ➤ **Memphis, TN^{N}**: The number of preadolescent users in the community, outside of the program, is increasing. ➤ **Sioux Falls, SD^{N}**: The number of preadolescent (<13 years) and adolescent (13–17 years) users is increasing.
Only one gender shift is reported:	➤ **Memphis, TN^{E}**: The number of female users has increased.
Racial/ethnic distributions have remained relatively stable, with two exceptions:	➤ **El Paso, TX^{M}**: While marijuana users are primarily Hispanics, more White people are being seen. ➤ **Memphis, TN^{E}**: Marijuana use, equally common among both Blacks and Whites, has increased among both groups.
Two treatment sources note changes in their clients' employment status:	➤ **New York, NY^{M}**: While users are still predominantly unemployed, employment has increased slightly, both at admission and during treatment. Parolees tend to be employed more. ➤ **Sioux Falls, SD^{N}**: The number of unemployed clients has increased, as has the number who are marijuana dealers.

- **Miami, FL^{M}**: Blunts are increasing, and blunt wraps are a new phenomenon.
- **Philadelphia, PA^{E}**: People are switching daily from blunts to flavored blunt wraps. Sales outlets are becoming more prevalent, and these places are staying open later.
- **Washington, DC^{E}**: Blunts are becoming less common. Joints are "in," and flavored papers for joints are becoming more popular.

A market strategy aimed at girls...

El Paso, TX^{E}: Sold at convenience stores, headshops, and drug stores, particularly in the downtown area, wraps are longer than regular cigarette joint papers. They are particularly aimed at girls, who like the various colors and flavors, such as strawberry, banana, and orange.

Where and with whom is marijuana used? Only one change is reported since the last *Pulse Check*: in El Paso, users are smoking marijuana more openly, in broad daylight, in public places, whereas in the past, use tended to be more private. Elsewhere, as reported in the last *Pulse Check*, epidemiologic/ethnographic and non-methadone treatment sources generally continue to agree that marijuana is equally likely to be used either publicly or privately. Methadone treatment sources, however, still tend to report more private than public use. Most sources also report either that users are more likely to smoke marijuana in small groups rather than alone, or else that small-group use and solo use are equally likely. However, five sources report solo use as more likely, and four of those five are methadone treatment sources (from Chicago, El Paso, New York, and Seattle). The variety of specific use settings reported by all sources is innumerable.

What other drugs do marijuana users take? Three new developments are reported since the last *Pulse Check*:

- **El Paso, TX^{E}**: A new drug is being used with marijuana: ketamine ("special K").
- **El Paso, TX^{M}**: Clients are smoking joints laced with cocaine.
- **New Orleans, LA^{E}**: Use of marijuana laced with PCP is making a comeback.

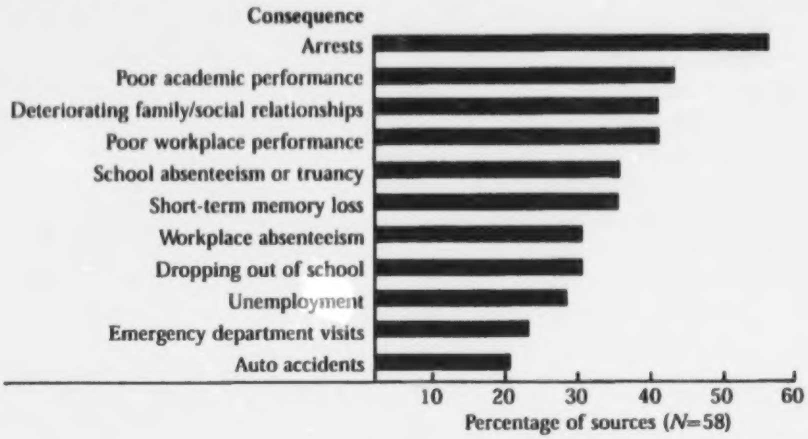
Elsewhere, marijuana frequently continues to be used with alcohol, and it continues to be smoked with a variety of other substances, either sequentially or in combination:

- **Benzodiazepines**: Boston, Memphis, and Philadelphia
- **Club drugs (such as ecstasy, ketamine, LSD)**: Boston, Columbia (SC), El Paso, Los Angeles, and Portland (ME)
- **Crack**: Chicago, Columbia, Denver, Honolulu, Memphis, New Orleans, New York, Philadelphia, and St. Louis (Crack combined with marijuana is referred to as "primos" in Denver and Memphis and "turbos" in Philadelphia.)
- **Formaldehyde**: Seattle ("Sherms" or "s" refer to this combination.)
- **Heroin**: Boston, Chicago, El Paso, Miami, New Orleans, New York, and Portland (ME) (In New York, "woolie" or "woola blunt" are slang names for heroin and marijuana in combination.)
- **Methamphetamine**: Billings, Denver, Honolulu, and Sioux Falls
- **Other opiates**: Boston, Memphis, and Philadelphia
- **PCP**: Chicago, Los Angeles, New Orleans, Philadelphia, Portland, and Sioux Falls (PCP in combination with marijuana is called "joy stick" or "happy stick" in Boston and "loveboat" or "wet" in Philadelphia.)
- **Powder cocaine**: Boston, El Paso, Honolulu, Memphis, Miami, New York, and Philadelphia ("Greek" refers to this combination in Miami.)

What are the consequences of marijuana use? *(Exhibit 10)* In trying to assess the consequences of marijuana use, many factors come into play, including the other drugs sometimes combined with marijuana. However, as the following examples indicate, some *Pulse Check* sources do note adverse consequences—sometimes medical, sometimes societal—involving the marijuana-using populations with whom they have contact:

- **Baltimore, MD^{M}**: A high percentage of clients have asthma, and marijuana makes the condition worse.
- **Boston, MA^{N}**: Clients who use marijuana have reduced incentive, and some even experience paranoia.
- **Los Angeles, CA^{N}**: Non-motivation is a problem among marijuana-using clients.
- **Memphis, TN^{E}**: Several marijuana dealers involved in gang-related crimes have been shot.
- **Miami, FL^{E}**: Marijuana is associated with high-risk sexual behavior in adolescents. It has been detected, often without other drugs, in many adolescent and young adult homicide victims. Among recent marijuana-related emergency department episodes, substantial percentages have been reportedly due to (in descending order) depression or suicide ideation, psychotic episodes (such as hallucinations, anxiety, bizarre behavior, or delusions), trauma (accidents), altered mental status, and chest pain.
- **New York, NY^{M}**: Clients who use marijuana are more likely to experience depression.
- **Philadelphia, PA^{E}**: Emergency department visits involving marijuana have increased. Philadelphia now has the highest rate in the country.
- **Sioux Falls, SD^{N}**: Mental health issues have been increasing among marijuana-using clients, including new admissions.

Exhibit 10.
What adverse consequences do substantial percentages* of *Pulse Check* sources attribute to the use of marijuana, either alone or in combination with other drugs?



**>20 percent*
Sources: Epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents

METHAMPHETAMINE[*]

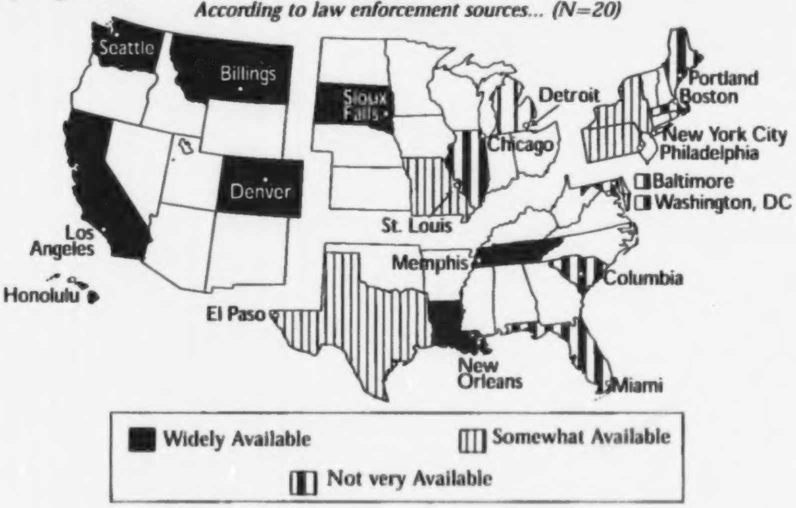
Methamphetamine is reported as an emerging or intensifying problem in 10 cities: Columbia (SC), Denver, Detroit, El Paso, Memphis, Miami, New York, St. Louis, Seattle, and Sioux Falls (*see Highlights Exhibit 6*). Furthermore, sources believe the drug contributes to the most serious consequences in eight cities, particularly in the West: Billings, Denver, Honolulu, Los Angeles, Memphis, St. Louis, Sioux Falls, and Seattle (*see Highlights Exhibits 3 and 4*). It is considered the most widely abused drug by sources in Billings, Denver, Honolulu, and Memphis. Since the last reporting period, law enforcement sources believe methamphetamine has replaced powder cocaine in Denver and marijuana in Memphis, as the drug contributing to the most serious consequences (*see Highlights Exhibit 5*).

METHAMPHETAMINE: THE DRUG

How available is methamphetamine, in its various forms, across the country? (*Exhibits 1 and 2*) Methamphetamine is still not very available according to many (16 of 40) law enforcement and epidemiologic/ethnographic sources. However, 13 sources consider it widely available, particularly throughout the West, and 11 consider it somewhat available.

Exhibit 1.
How available is methamphetamine across the 20 *Pulse Check* cities (spring 2002)?

According to law enforcement sources... (N=20)


Seattle
Billings
Sioux Falls
Denver
Los Angeles
Honolulu
El Paso
St. Louis
Memphis
New Orleans
Chicago
Detroit
Portland
Boston
New York City
Philadelphia
Baltimore
Washington, DC
Columbia
Miami
Widely Available
Somewhat Available
Not very Available

According to epidemiologists/ethnographers... (N=20)

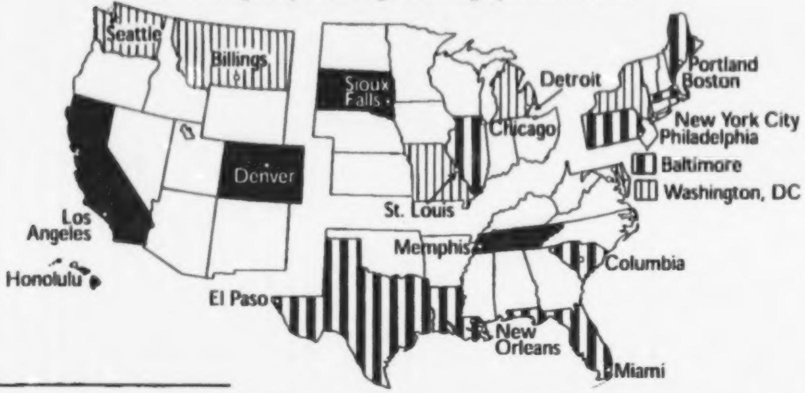

Seattle
Billings
Sioux Falls
Denver
Los Angeles
Honolulu
El Paso
St. Louis
Memphis
New Orleans
Chicago
Detroit
Portland
Boston
New York City
Philadelphia
Baltimore
Washington, DC
Columbia
Miami

Exhibit 2.
How has methamphetamine availability changed (fall 2001 vs spring 2002)?

Boston, MA^{L}
Billings, MT^{L}
Chicago, IL^{L,E}
Columbia, SC^{L}
Denver, CO^{L}
Detroit, MI^{E}
Honolulu, HI^{E}
Los Angeles, CA^{E}
Memphis, TN^{L,E}
Miami, FL^{E}
New York, NY^{L,E}
Sioux Falls, SD^{E}

Baltimore, MD^{L,E}
Billings, MT^{E}
Boston, MA^{E}
Columbia, SC^{E}
Denver, CO^{E}
Detroit, MI^{L}
El Paso, TX^{L,E}
Honolulu, HI^{L}
Los Angeles, CA^{L}
Miami, FL^{L}
New Orleans, LA^{L,E}
Philadelphia, PA^{L,E}
Portland, ME^{L,E}
St. Louis, MO^{L,E}
Seattle, WA^{L,E}
Sioux Falls, SD^{L}
Washington, DC^{L,E}

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[*] *The following symbols appear throughout this chapter to indicate type of respondent: ^{L}Law enforcement respondent, ^{E}Epidemiologic/ethnographic respondent, ^{N}Non-methadone treatment respondent, and ^{M}Methadone treatment respondent.*

BEST COPY AVAILABLE

Since the last reporting period, the number of small, local methamphetamine labs increased in nine *Pulse Check* cities...

Despite the increases, however, availability levels remain low in many of these cities:

- **Boston, MA**[L]: Four box labs were seized. None had ever been seized before.
- **Chicago, IL**[L]: Clandestine labs were seized for the first time.
- **Denver, CO**[L]: Seizures of box labs, especially in hotels or motels where they now have interdictions, have increased.
- **Detroit, MI**[E]: The number of clandestine labs has increased.
- **Los Angeles, CA**[L]: The number of small labs continues to increase, but large operations still predominate.
- **Miami, FL**[E]: Seven small labs were seized for the first time.
- **Portland, ME**[L]: An increase in labs over the past 2 or 3 years involves mostly Mexican migrant workers, some transplanted from the Southwest. Most of that methamphetamine, however, is believed to be going to Canada, rather than the local streets.
- **St. Louis, MO**[E]: While stationary labs still predominate, mobile labs are growing in popularity. Cooking in cars and trucks helps producers in two ways: it eludes identification by law enforcement; and motion helps the chemical reaction. Motels are a new production setting during this reporting period: the temporary nature of these setups, again, challenges disruption efforts. Clandestine labs are also set up in Federal parklands, where toxic byproducts pose a danger to hikers and campers.
- **Sioux Falls, SD**[L,E]: Both local box labs and large operations have increased. Production has shifted from the cold method to the nazi method.

Locally produced methamphetamine seems slightly more available than Mexican methamphetamine across the *Pulse Check* cities: 21 sources rate the local product as either somewhat or widely available, whereas only 17 sources give those ratings to the Mexican product.

Since the last reporting period, methamphetamine availability (all varieties combined) has remained stable, according to the majority (25 of 40) of law enforcement and epidemiologic/ethnographic sources in 17 sites. The remaining sources (15 in 12 sites) believe it has increased. No declines are reported for any varieties.

Only four sources (in Billings, Denver, Los Angeles, and Memphis) believe that Mexican methamphetamine has increased. By contrast, locally produced methamphetamine has increased in 12 cities: Billings[L], Boston[L], Chicago[L], Denver[L], Detroit[E], Los Angeles[E], Memphis[L,E], Miami[E], New York[L], Portland (ME)[L], Sioux Falls[E], and Washington, DC[E].

Availability of "ice," nearly 100 percent pure methamphetamine, is generally stable, but it has increased in Billings, Denver, Honolulu, and Memphis—the only cities where it is considered somewhat or widely available.

What are street-level methamphetamine prices and purity levels across the country? *(Exhibit 3)* Gram prices are most commonly reported at about $100, but they range from $20–$60 in Seattle to $330 in Chicago. The highest reported purities are in Honolulu and Seattle. In Seattle, locally produced methamphetamine is more pure than Mexican methamphetamine, which continues to be diluted with methylsulfonylmethane (MSM). Mexican national traffickers are also starting to cut methamphetamine with MSM in Los Angeles, but purity there has nevertheless increased at the ounce level (from 15–20 percent to 30–35 percent) since the last reporting period. Only one other shift is reported since the last period: in Honolulu, the 1/4 gram price of ice, also known as "clear," declined by 20 percent. All other prices and purity levels are stable.

How is methamphetamine referred to across the country? *(Exhibit 4)* Methamphetamine continues to be called by long-standing names, such as "meth," "speed," "crank," and "crystal." Other slang terms are often based on the color, consistency, appearance, or weight of the local product. Only a few terms are newly reported during this period (but are not necessarily new), including the following: "crystal methedrine" (Boston[N]); "CR" (Sioux Falls[L]); "fast" (Denver[L]); "geeter" and "work" (Billings[N]); and "peanut butter," "pink hearts," "poppers," "rock," "tweak," and "yellow jackets" (St. Louis[E]).

METHAMPHETAMINE: THE MARKET

Who sells methamphetamine? Sellers continue to be predominantly independent operators, according to law enforcement and epidemiologic/ethnographic sources. Organized sales structures, however, are reported in Billings, Detroit, and El Paso, while both types of structures are reported in Chicago, Denver, Los Angeles, Memphis, Philadelphia, St. Louis, and Seattle. Sometimes, as in Denver and St. Louis, independent sellers tend to sell locally produced methamphetamine, while organized groups sell the Mexican product.

Young adults (18–30 years) are generally the predominant seller groups. However, adults (>30 years) are mentioned in Honolulu, Philadelphia, Portland (ME), and St. Louis, while both groups are mentioned in Billings, Boston, and Sioux Falls. Adolescents (13–17 years) sell methamphetamine in New Orleans (where they are the predominant group), Los Angeles, and Memphis.

Similar to reports in the last few *Pulse Checks*, more than half of respondents believe methamphetamine sellers are very likely to use the drug. In many cases, as in El Paso, sellers process their own methamphetamine, so they are particularly likely to use it.

What types of crimes are related to methamphetamine sales? *(See Highlights Exhibit 7)* In general, the level of criminal activity appears to be relatively stable since the last *Pulse Check*. Similar to findings in the last *Pulse Check*, methamphetamine accounts for 33 percent of domestic violence among drug sellers, as reported by law enforcement and epidemiologic/ethnographic respondents—compared with 28 percent for powder cocaine, 19 percent for crack, 11 percent for heroin, and 8 percent for marijuana. It also accounts for substantial percentages of nonviolent crime (20 percent), violent crime (16 percent), prostitution (15 percent), and gang-related crimes (12 percent) among sellers. Examples of reported violent crimes include turf wars and shootings in Sioux Falls. Examples of nonviolent crimes include theft of precursors or other materials to set up labs (in El Paso and Memphis), gun possession (in Los Angeles), and burglary or theft (in Billings, Los Angeles, St. Louis, and Sioux Falls).

Exhibit 3.
How much does methamphetamine cost in 13 *Pulse Check* cities?

	City	Gram price	Other price/unit
South	Columbia, SC^{L}	$175	NR
	Columbia, SC^{E}	NR	$40/ 2oz liquid
	El Paso, TX^{L}	NR	$20/ 3oz g
	Memphis, TN^{L}	$125	NR
	Memphis, TN^{E}	$100	NR
	New Orleans, LA^{L}	$100	NR
Midwest	Chicago, IL^{L}	$330	NR
	Detroit, MI^{E}	$100	NR
	St. Louis, MO^{L}	$100	NR
	St. Louis, MO^{E}	(outside city) $37–$100	$700–$1,300/oz
	Sioux Falls, SD^{L}	NR	("eightball") $150–$225/ coz $9,000–$11,000/lb
West	Billings, MT^{L}	(powder) $100 (crystal) $125	NR
	Denver, CO^{L}	$100–$150	NR
	Denver, CO^{E}	[a]$90–$110	[b]$700–$1,200/oz
	Honolulu, HI^{L}	$200–$300	$50–$100/ 3g
	Honolulu, HI^{E}	$100–$200	[c]$50/ 3g
	Los Angeles, CA^{L}	NR	[d]("teener") $125/ 1/16oz
	Los Angeles, CA^{E}	NR	[e]$500–$700/oz ("eightball") $100–$120/ coz ("teener") $60/ 1/16oz
	Seattle, WA^{L}	[f]$20–$60	[f]$350–$650/oz
	Seattle, WA^{E}	$20–$60	NR

Reported purities

[a]10–20%	[d]40%
[b]10–20%	[e]30–35%
[c]95%	[f]95% nazi method; 75% red phosphorus method

NR=not reported
Sources: Law enforcement and epidemiologic/ethnographic respondents

What other drugs do methamphetamine sellers sell? Methamphetamine dealers sell no other drugs according to respondents in eight cities: Chicago^{L}, Columbia (SC)^{L}, El Paso^{L}, Los Angeles^{L}, Memphis^{L}, Philadelphia^{L}, Portland (ME)^{L}, and St. Louis^{L,E}. Among those who do sell other drugs, they include:

- **Crack:** Billings^{L}, Denver^{L,E}, El Paso^{E}, and Sioux Falls^{L}
- **Powder cocaine:** Denver^{E}, El Paso^{E}, Honolulu^{L}, New Orleans^{L}, and Washington, DC^{L}
- **Heroin:** Denver^{E} and Honolulu^{L}
- **Marijuana:** Baltimore^{L}, Denver^{L,E}, Honolulu^{L,E}, Memphis^{E}, Seattle^{L}, and Sioux Falls^{L}
- **Ecstasy:** Baltimore^{L}, El Paso^{E}, and Washington, DC^{L}

The El Paso epidemiologic source points out that methamphetamine dealers "would go broke if they didn't sell other drugs." No significant changes are reported during this reporting period in the other drugs sold.

The methamphetamine market has changed somewhat (fall 2001 vs spring 2002)...

Market disruptions have caused declines in availability:	➤ **Philadelphia, PA**[L]: The market has continued its 5-year decline due to two disruptions: precursors were made less available; and numerous lab operators and chemists were arrested. ➤ **Los Angeles, CA**[E]: After pseudoephedrine prices rose, that precursor was mostly smuggled from Canada. But, with heightened border control since September 11, not as much is getting through. For example, a large bust at the Michigan border was directly related to the lower supply in Los Angeles.
Increases in both younger and older sellers are reported in some cities:	➤ **Baltimore, MD**[L]: Adolescents are now involved in sales. ➤ **Billings, MT**[L,E]: Older adults are increasingly selling. ➤ **Memphis, TN**[E]: Sellers are getting younger. ➤ **Seattle, WA**[E]: Age range has broadened: while sellers are still predominantly young adults, adolescents and older adults are increasingly involved. ➤ **Sioux Falls, SD**[E]: Older adults (55–65 years) have been caught selling during the past year.
The market is shifting geographically:	➤ **Chicago, IL**[L]: Labs have been seized inside the city for the first time. ➤ **Memphis, TN**[E]: Sellers are increasingly moving to more rural areas. ➤ **Miami, FL**[E]: Seven small labs were seized for the first time: in the past, such seizures occurred only in western and central Florida. ➤ **New York, NY**[L]: Local methamphetamine has spread from Upstate New York into the Long Island area. ➤ **St. Louis, MO**[E]: People are moving production from rural into city and suburban areas. Entrepreneurs see these areas as untapped markets and are establishing new connections. ➤ **Seattle, WA**[L]: Law enforcement pressure has pushed markets further out into previously unaffected areas. Almost all counties in Washington are reporting some activity: any leveling off in previous hot spots has been offset by increases in rural areas.
New market settings are noted in a few cities:	➤ **Chicago, IL**[L]: Street sales are noted for the first time, mostly on the North Side. However, methamphetamine is not sold at the same locations as crack or heroin. ➤ **Columbia, SC**[L]: Methamphetamine sales are reported in nightclubs and bars for the first time. ➤ **Memphis**[L]: Methamphetamine is now being sold on the Internet. ➤ **Seattle, WA**[L]: Some people now openly sell methamphetamine as such, not disguised as ecstasy, at dances, raves, and other events.
Trafficking has been linked to terrorism:	➤ **New York, NY**[L]: Several cases of pseudoephedrine diversion have involved terrorist groups who traffic drugs (including heroin) to fund their activities.

How is street-level methamphetamine sold? Disrupting methamphetamine sales is challenging because, as the vast majority of law enforcement and epidemiologic/ethnographic respondents report, it is primarily sold hand-to-hand, usually via acquaintance networks or personal introduction, and usually at a clandestine, predetermined meeting place. Sometimes beepers and cell phones are involved in these transactions (as in Honolulu, Los Angeles, Memphis, St. Louis, and Sioux Falls), and occasionally runners are involved (as in El Paso). Open methamphetamine markets in specific neighborhoods are mentioned in only a handful of cities (Chicago, Denver, Detroit, New Orleans, and Philadelphia).

Where are methamphetamine markets located? The geographic location of methamphetamine markets varies widely, according to law enforcement and epidemiologic/ethnographic respondents. Regional differences are less apparent than they were in the last *Pulse Check.*

- All areas (central city, suburban, and rural) are the scene of methamphetamine sales in cities spanning all regions: Baltimore[L], Billings[L], Denver[L,E], Detroit[E], Memphis[L], Philadelphia[L], Seattle[L], and Sioux Falls[L].
- Central city selling locations are more prominent in Honolulu[L], New Orleans[L], and Washington, DC[L].
- Both central city and suburban selling locations are reported in Chicago[L], Honolulu[E], and Los Angeles[L].

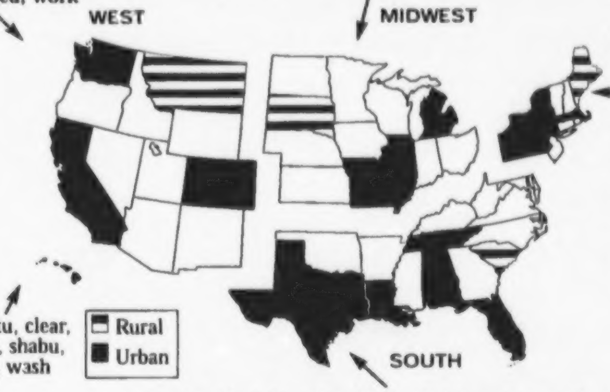
- Both central city and rural selling areas are reported in Memphis[E].
- Nearby rural areas are the primary sales locations reported in Boston[L], Portland[L], and St. Louis[L,E].
- Suburban areas are the most common selling sites in Columbia (SC)[L] and El Paso[L,E].

More than half of responding law enforcement and epidemiologic/ ethnographic sources report that methamphetamine is sold both indoors and outdoors. However, sales take place primarily indoors in eight cities: Boston[L], Chicago[L], Columbia[L], El Paso[L], New Orleans[L], Portland (ME)[L], St. Louis[L,E], and Washington, DC[L].

Similar to reports in previous *Pulse Checks*, private residences are the most frequently mentioned specific settings for methamphetamine sales across *Pulse Check* cities. The next most common settings are nightclubs or bars, private parties, raves and concerts, and hotels or motels. Respondents also frequently mention cars, parks, public housing developments, schools, and college campuses. Less frequently mentioned sales locations (six or fewer respondents) include in or around malls (in Baltimore, Billings, Denver, Honolulu, Memphis, and Philadelphia), supermarkets (in Baltimore, Billings, Denver, Memphis, and Philadelphia), crack houses (in Billings, Denver, Honolulu, Philadelphia, and Sioux Falls), and around treatment clinics (in Baltimore, Denver, Memphis, and Philadelphia). Crack houses in Sioux Falls are known as "meth houses."

Exhibit 4.

How is methamphetamine referred to in the four regions of the country?*



West: **Crank, crystal, fast, geeter, glass, ice, meth, speed, work**

Midwest: Anhydrous, bathtub meth, black, **black beauty**, brown, CR, california, chemical, **christmas trees, crank, crystal**, fire, **getgo, glass, ice, meth**, nazimeth, **peanut butter**, pink, **pink hearts, poppers**, red, **rock, soap**, spackle, **speckled birds, tweak**, white, white crosses, **yellow jackets**

Northeast: **Crank, crystal, crystal meth, crystal methedrine, eightballs, elbows (1 pound), half elbows (½ pound), glass,** ice, OZs, **quarter ounces, meth, speed**

Hawaii: Batu, clear, ice, shabu, tic, wash

South: Beannies, black beauties, blade, christmas tree meth, cinnamon, **crank, crys, crystal, crystal meth**, holiday meth, ice, meth, **speed, sugar**

**Bolded names are newly reported during this reporting period (but are not necessarily new).*

Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

METHAMPHETAMINE: THE USERS

How many methamphetamine users are in treatment? *(Exhibit 5)*

Among programs represented by *Pulse Check* treatment sources, only a handful have substantial percentages of people who report methamphetamine use. In addition to the increases noted in the table, some increases are reported in treatment programs where the numbers are still relatively low, as in Columbia (SC)[N] and Denver[N].

Who uses methamphetamine?

Methamphetamine users across *Pulse Check* cities are likely to be either young adults (18–30 years) or adults older than 30. Average mean age, based on information provided by treatment and epidemiologic/ ethnographic sources across the sites, is 29.2 (*n*=13). Adolescents, however, are named as the predominant users by four non-methadone treatment sources: in Billings, Columbia (SC), Los Angeles, and Sioux Falls. Males are the predominant users according to sources in 12 cities, but sources in 8 cities indicate that men and women are equally likely to use methamphetamine. More women than men use the drug according to sources in three cities: Columbia (SC)[E,N], El Paso[E], and Memphis[M]. In El Paso, many of the female users are dancers, many are unemployed, and many use it either for weight loss or for increased energy.

Methamphetamine users continue to come from predominantly low or low-to-middle socioeconomic groups. Those in treatment tend to be

Exhibit 5.

Which treatment programs in *Pulse Check* sites have substantial percentages[a] of clients reporting methamphetamine use? How have those percentages changed (fall 2001 vs spring 2002)?

City/Program	Primary use	Any use[b]	Fall 2001 vs Spring 2002
Billings, MT^{N}	17%	32%	Stable
Honolulu, HI^{N}	68%	NR	Some increase
Honolulu, HI^{M}	0	10%	Some increase
Los Angeles, CA^{M}	0	8%	Stable
St. Louis, MO^{N}	Approximately 12%[c]	NR	Stable
St. Louis, MO^{M}	0	10%	Some increase
Seattle, WA^{N}	7%	7%	Some increase
Sioux Falls, SD^{N}	>80%[d]	100%	Large increase

[a] 7 percent or more

[b] Primary + secondary + tertiary use

[c] 35 percent among rural residents, 1.5 percent among central city residents

[d] A small program for adolescents only

Sources: Non-methadone and methadone treatment providers

unemployed, and the majority are court referred. Users also continue to be primarily Whites, according to all but two of the reporting *Pulse Check* sources: Asian/Pacific Islanders predominate in the Honolulu non-methadone treatment program, and Hispanics predominate in the Los Angeles non-methadone program. The Los Angeles epidemiologic source notes a gradual increase in Asian/Pacific Islanders in treatment, though their numbers remain low. American Indians are mentioned as users in Billings and Sioux Falls; Hispanics are mentioned in Denver and Sioux Falls; and Blacks are mentioned in Columbia, Miami, Memphis, and Sioux Falls.

How, where, and with what other drugs do users take methamphetamine? Methamphetamine can be smoked, injected, snorted, or taken orally, and these routes of administration continue to vary widely across the *Pulse Check* cities. Often, several routes are equally likely in a given city. A few changes are noted since the last *Pulse Check*:

- **Billings, MT^{N}**: Smoking is increasing, but injecting remains common.
- **Honolulu, HI^{E}**: A small group of injectors is emerging, but nearly all users still smoke.
- **Los Angeles, CA^{M}**: While injecting still predominates, newer users tend to smoke.
- **Memphis, TN^{E}**: Users are generally shifting from smoking and oral use to snorting.
- **Sioux Falls, SD^{E}**: New younger (15–16 years) methamphetamine users tend to move fairly quickly from snorting and smoking to injecting.

Methamphetamine tends to be used in private settings, often in small groups among friends. Private residences remain the most commonly mentioned use settings, followed by private parties. Other common settings include nightclubs, cars, public housing developments, college campuses, and hotels or motels.

Methamphetamine is often associated with the gay scene...

- **Boston, MA^{E}**: Methamphetamine use is limited to gay clubs.
- **Los Angeles, CA^{E}**: Methamphetamine is often used in the gay party scene.
- **Miami, FL^{E}**: Methamphetamine has generally been available only in the gay community in the techno dance scene on Miami Beach, where users sell the drug to one another. However, it may be spreading through that venue to other populations, in the same way that ecstasy grew out of the club scene, as evidenced by increased activity in emergency departments: DAWN mentions of amphetamine/methamphetamine outnumber those involving ecstasy.
- **New York, NY^{E}**: Methamphetamine use has increased in gay communities. One gay men's organization is now holding three to eight methamphetamine-related meetings per week, primarily because of the increase in methamphetamine-related HIV.

Marijuana remains the most commonly reported drug taken by methamphetamine users. The two drugs are usually used sequentially, but sometimes they are combined, as reported in Detroit, Memphis, Portland (ME), and Sioux Falls (where "lacing" is increasing). Several other drugs are mentioned:

- **Benzodiazepines, such as alprazolam (Xanax®) or diazepam**: Honolulu, Los Angeles, Memphis, Philadelphia, and Portland
- **Club drugs, such as ecstasy, GHB, and amylnitrate ("poppers")**: Los Angeles
- **Crack**: Memphis

- **Depressants, such as phenobarbital:** El Paso
- **Heroin:** Boston and Seattle
- **Powder cocaine:** Portland
- **Prescription opiates:** Billings, Columbia (SC), Los Angeles (particularly hyrocodone, or Vicodin®), and Memphis (particularly hydromorphone, or Dilaudid®).
- **Sildenafil (Viagra®):** Miami

Users on the move...

Methamphetamine users' residence locales continue to vary across different *Pulse Check* cities. Two contrasting trends continue to be noted:

- ➤ **Toward rural areas:** Users have been spreading into rural areas of Denver and Memphis, and into the reservation areas of Sioux Falls. In Memphis, this spread is related two trends: increased gang activities in rural areas and increased access to the rurally produced drug.
- ➤ **Away from rural areas:** In Los Angeles, use has been shifting from rural to central city and suburban areas because manufacture has spread. The St. Louis problem is also starting to creep into the city.

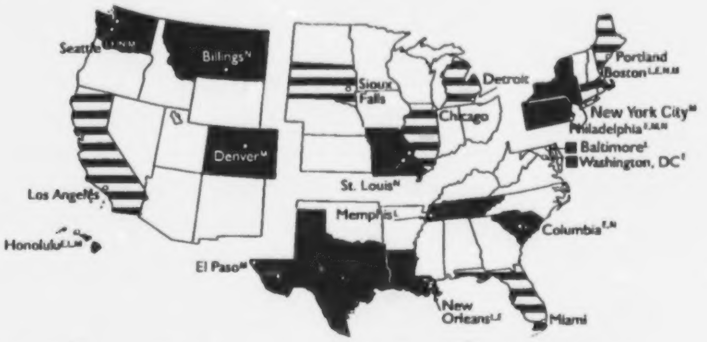
DIVERTED SYNTHETIC OPIOIDS⁺

This reporting period marks the third time that *Pulse Check* has monitored the illegal diversion and abuse of synthetic opioids, particularly OxyContin® (oxycodone hydrochloride controlled-release), prescribed to patients suffering from severe persistent pain—a legitimate medical need. Some signs indicate that diversion and abuse of this pharmaceutical might have peaked during the last reporting period. For example, two issues ago, the drug was described as an emerging problem by sources in 14 cities; that number increased to 18 cities in the last *Pulse Check*; and it is back down to 14 cities during the current reporting period.

How serious is abuse and diversion of synthetic opioids, and where is the problem emerging across the country? *(Exhibit 1)* Only the Miami law enforcement source considers OxyContin® the drug with the most serious consequences in a *Pulse Check* community—a decline from the last *Pulse Check*, when it was also considered the most serious problem in New Orleans and Portland (ME). It does, however, remain the second most serious problem in Portland^{M}, as well as in Billings^{L,N}, Columbia (SC)^{M}, El Paso^{M}, and Honolulu^{E}.

OxyContin® diversion and abuse is described as an emerging problem by law enforcement and epidemiologic/ethnographic sources in 14 cities. The six cities where no sources consider it an emerging problem during this period are Chicago, Detroit, Los Angeles, Miami, Portland, and Sioux Falls.

Exhibit 1.
Where is OxyContin® diversion and abuse emerging across the 20 *Pulse Check* cities?



■ OxyContin® reported as emerging in spring 2002

▤ OxyContin® not reported as emerging in spring 2002

Sources: Law enforcement, epidemiologic/ethnographic, non-methadone and methadone treatment respondents.

Chicago is the only *Pulse Check* city where the drug was not described as an emerging problem during any of the three latest reporting periods. That city's law enforcement source explains that the drug is not encountered on the street, although it has been reported in seizures.

In addition to OxContin®, diversion of methadone, another opiate, is reported as an emerging problem in Portland (ME). Diverted hydrocodone (Vicodin®) is increasingly available in New Orleans and is increasingly identified in poison control calls in Detroit. Other diverted opiates are becoming problematic in Billings, Boston, Columbia (SC), and Denver.

DIVERTED OXYCONTIN®: THE DRUG

How available is diverted OxyContin®? *(Exhibits 2 and 3)* Only four sources consider diverted OxyContin® widely available, but more than half of the law enforcement and epidemiologic/ethnographic sources describe it as somewhat available. Availability has remained stable in 13 cities according to half of the sources, has increased in 10 cities according to about one-third of the sources, and has declined in 4 cities according to 4 sources.

As the arrow exhibit shows, stable trends are particularly evident in the Midwest. The decline in Philadelphia is attributed to a combination of legislation, arrests, education, and press about deaths and arrests. Demand there, however, appears stable at high levels. In Portland (ME), the problem was at its highest point last year. Since then, prescriptions have declined, and pharmacists are not stocking as much. Educating doctors and pharmacists, changes in prescription policies, numerous conferences, and wide press coverage have all made a difference. By contrast, the increase in nearby Boston is evi-

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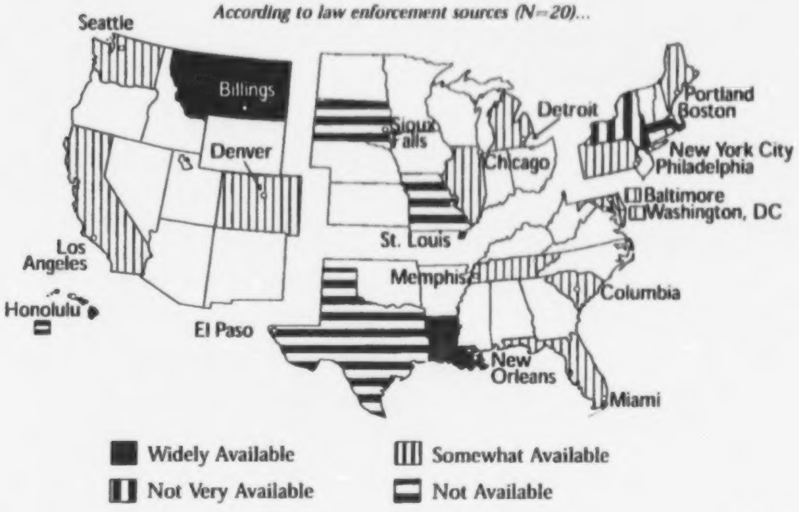
⁺*The following symbols appear throughout this chapter to indicate type of respondent: ^{L}Law enforcement respondent, ^{E}Epidemiologic/ethnographic respondent, ^{N}Non-methadone treatment respondent, and ^{M}Methadone treatment respondent.*

BEST COPY AVAILABLE

Exhibit 2.
How available is diverted OxyContin® across the 20 *Pulse Check* cities (spring 2002)?

According to law enforcement sources (N=20)...


Seattle
Billings
Denver
Los Angeles
Honolulu
El Paso
Sioux Falls
Chicago
Detroit
St. Louis
Memphis
New Orleans
Portland
Boston
New York City
Philadelphia
Baltimore
Washington, DC
Columbia
Miami
■ Widely Available
▥ Somewhat Available
▮ Not Very Available
▤ Not Available

According to epidemiologic/ethnographic sources (N=20)...

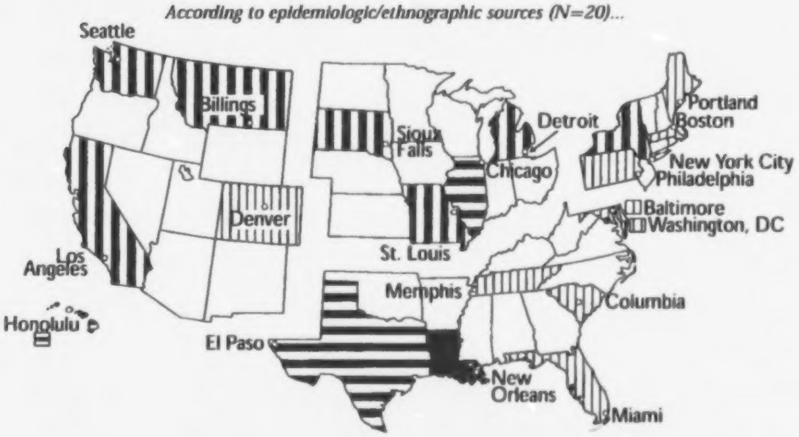

Seattle
Billings
Denver
Los Angeles
Honolulu
El Paso
Sioux Falls
Chicago
Detroit
St. Louis
Memphis
New Orleans
Portland
Boston
New York City
Philadelphia
Baltimore
Washington, DC
Columbia
Miami

Exhibit 3.
How has diverted OxyContin® availability changed (fall 2001 vs spring 2002)?*

Baltimore, MD^{L}
Boston, MA^{L,E}
Columbia, SC^{L,E}
Honolulu, HI^{L,E}
Los Angeles, CA^{L}
Memphis, TN^{L}
Miami, FL^{L}
New Orleans, LA^{E}
New York, NY^{L}
Seattle, WA^{L,E}

Baltimore, MD^{E}
Billings, MT^{L,E}
Chicago, IL^{E}
Denver, CO^{L,E}
Detroit, MI^{L,E}
El Paso, TX^{L,E}
Los Angeles, CA^{E}
New Orleans, LA^{L}
New York, NY^{E}
Philadelphia, PA^{E}
St. Louis, MO^{L,E}
Sioux Falls, SD^{L,E}
Washington, DC^{L,E}

Memphis, TN^{E}
Miami, FL^{E}
Philadelphia, PA^{L}
Portland, ME^{L}

**The Chicago law enforcement source and the Portland epidemiologic source did not provide this information.*

denced by a continued increase in pharmacy robberies. Furthermore, sales there appear more organized than in the past. In Honolulu, law enforcement officials are investigating "bad doctors," who seem to be writing more prescriptions.

How much does diverted OxyContin® cost? The most common price remains $1 per milligram, as reported by sources in Boston^{L}, Baltimore^{L}, Denver^{E}, Detroit^{L} Memphis^{E}, Honolulu^{E}, and Portland (ME)^{E}. Since the last *Pulse Check*, the Detroit epidemiologic source reports that the milligram price has increased from $1 to $1–$1.50. Conversely, prices declined in Boston^{E} (from $1 to $0.50–$1) and Philadelphia^{E} (from $1 to $0.50–$0.75). Stable prices are reported elsewhere. Other reported milligram prices include $2–$3 in Billings^{L}, $0.50–$1 in Honolulu^{L}, and $1.50–$2 in Washington, DC^{L}.

DIVERTED OXYCONTIN®: THE MARKET

How is OxyContin® diverted? Numerous diversion techniques continue: forging, doctoring, or manipulating prescriptions; feigning

Diverted OxyContin® goes by many slang terms...

- **"Oxy" or "oxys"**: The most commonly reported terms
- **"OCs"**: Boston, MA; Billings, MT
- **"Ox"**: Columbia, SC; New Orleans, LA
- **"Os"**: Philadelphia, PA
- **"Oxycotton"**: Columbia, SC
- **"40s" and "80s"**: Miami, FL
- **"Blue" and "valerie"**: Memphis, TN
- **"Cotton"**: St. Louis, MO
- **"Killer"**: A new term in Billings, MT
- **"Pills"**: New Orleans, LA
- **"Rush"** A new term in Portland, ME

illness, then selling legitimate prescriptions ("doctor shopping"); robbing pharmacies; unscrupulous doctors or other health professionals selling legitimate prescriptions or running pain clinics; and pharmacists or other pharmacy staff committing prescription theft or fraud. The diverted drug sometimes comes into communities from other States or countries. For example, some pills enter Detroit from Indiana and via the Canadian border.

Since the last reporting period, prescription fraud and diversion from pain clinics have been declining in Miami, as authorities have identified and prosecuted physicians. Similarly, in Portland (ME), pharmacy thefts are continuing to decline, despite a recent break-in in the suburbs involving 5,000 doses.

By contrast, in nearby Boston, people are increasingly paying (in money or pills) or duping others into robbing pharmacies for them. The actual robbers fall into two groups: armed, businesslike professionals; and addicts, "low professionals," and second stringers. Additionally, a new practice is reported in Boston: swapping sex (with doctors) for prescriptions. An increasing amount of OxyContin® is also being diverted in New York. In Philadelphia, unlicenced pharmacy technicians are becoming an increasing source of diversion. In the West, doctors and pharmacists in Seattle are getting bolder and more active and are increasing in number, so State agencies are increasingly paying attention. Similarly, in Honolulu, prescription fraud is increasingly coming to the attention of authorities.

Who sells diverted OxyContin®? As reported in the last *Pulse Check*, nearly all law enforcement and epidemiologic/ethnographic sources report that sellers of diverted OxyContin® are predominantly independent. Miami and New Orleans remain exceptions, with organized sales structures predominating. Both independent and organized sales are reported in Baltimore and Los Angeles. Sellers tend to be young adults (18–30 years) or adults (>30 years), according to all respondents, with both age groups mentioned an equal number of times, as in the last *Pulse Check*. They are somewhat or very likely to use the drug themselves, according to more than half of responding law enforcement and epidemiologic/ethnographic sources.

These seller characteristics appear relatively stable, with two exceptions: in Boston[L], sellers continue to be increasingly younger; and in Columbia (SC)[L], sellers are now somewhat likely to use their own drug—a change from the last *Pulse Check*, when they were not at all likely to do so.

What types of crimes are related to diverted OxyContin® sales? Sellers of this diverted pharmaceutical are involved in nonviolent crimes in nine *Pulse Check* cities. Specifically, fraudulent or stolen prescriptions are mentioned in Boston, Columbia (SC) (where this activity is a new development), and Memphis; and robbery, burglary, larceny, and other property crimes are mentioned in Billings, Boston, Baltimore, and New Orleans. Violent crimes are mentioned by law enforcement sources in Boston, Honolulu, Los Angeles, and Portland (ME). Prostitution is mentioned in Baltimore and Billings.

What other drugs are sold by diverted OxyContin® sellers? As reported in the last two *Pulse Checks*, other prescription opiates and heroin are the most common other drugs sold by diverted OxyContin® sellers.

Diverted OxyContin® sellers: A closer look...

- **Boston, MA[L]**: One seller group consists of well-armed professionals who rob pharmacies and are in sales strictly for the business. Another group consists of addicts, second stringers, and "low professionals."
- **Columbia, SC[L]**: Diverted OxyContin® is often sold by female senior citizens known as "pill ladies." Additionally, some users are now beginning to sell the drug.
- **Seattle, WA[L]**: Clear and substantiated evidence has emerged during this reporting period that doctors and pharmacists are involved in selling diverted OxyContin®.

according to law enforcement and epidemiologic/ethnographic sources in seven cities (Boston, Columbia [SC], Honolulu, Miami, Philadelphia, Portland [ME], and Washington, DC). Other drugs sold include marijuana and methamphetamine in Billings; cocaine in Boston; crack cocaine in Miami; other prescription pills, such as benzodiazepines or clonidine (Catapres®), in Memphis and Washington, DC; and ecstasy and GHB in New Orleans.

Where are diverted OxyContin® markets located? Contrary to the widespread belief that OxyContin® diversion is a rural phenomenon, law enforcement and epidemiologic/ethnographic sources in eight cities (Billings, Boston, Columbia [SC], Honolulu, Los Angeles, Philadelphia, Portland [ME], and Washington, DC) report that sales occur primarily in central city locations. In another five cities, sources report that markets for the diverted pharmaceutical are located in all types of areas (central city, rural, and suburban). Rural areas are the primary location according to only one source (Detroit[L]), the suburbs predominate according to one other source (New Orleans[L]), and both suburban and rural areas are the primary locations according to two sources (Detroit[E] and Memphis[E]).

Markets in many indoor settings...

Private residences are the most commonly specified indoor sales location. Other examples include the following:

- **Nightclubs and bars**: Memphis, New Orleans, and Philadelphia
- **In or around supermarkets**: Billings, Memphis, and Washington, DC
- **In or near treatment clinics**: Billings, Memphis Phildelphia, and Washington, DC
- **Cars**: Billings, Memphis, and Portland

Markets are located predominantly indoors according to sources in eight cities. Both indoor and outdoor sales are reported in six cities. Outdoor sales predominate only in two cities: in Miami, OxyContin® is sold on the street in some neighborhoods, such as Liberty City and Little Haiti, sometimes in the same places where crack is sold; similarly, in Washington, DC, open-air markets are located in certain areas. In New York, the drug has not emerged as a street drug at this time: only two incidents of street contacts are reported by street researchers during this reporting period, despite increased emphasis on tracking street activity.

Two changes are reported since the last *Pulse Check*, both in the South. In Memphis, sales had been confined to suburban indoor locations but are now spreading onto the streets. Similarly, in New Orleans, sales are now spreading beyond the housing projects where they were previously confined.

How is diverted OxyContin® sold? Sales techniques vary from city to city. Therefore, disrupting the market requires a wide range of strategies. For example, it is particularly difficult to track diversion and make arrests in Boston because dealers do not generally sell diverted OxyContin® to people they don't know. Rather, they have a set of customers who page them, tell them what they want, and have the drugs home delivered—similar to transactions in that city involving heroin, powder cocaine, and marijuana. In nearby Portland, diverted OxyContin® sales are also similar to heroin sales, so the two drugs could be targeted with similar disruption strategies. Occasionally, in that city, word gets out quickly when someone has diverted a large amount of OxyContin®, and users swarm to that individual, creating a disruption opportunity. Elsewhere in the Northeast, in Philadelphia, some users obtain their drug by loitering around treatment centers and homeless shelters, while others get it directly from the diversion source: pharmacies.

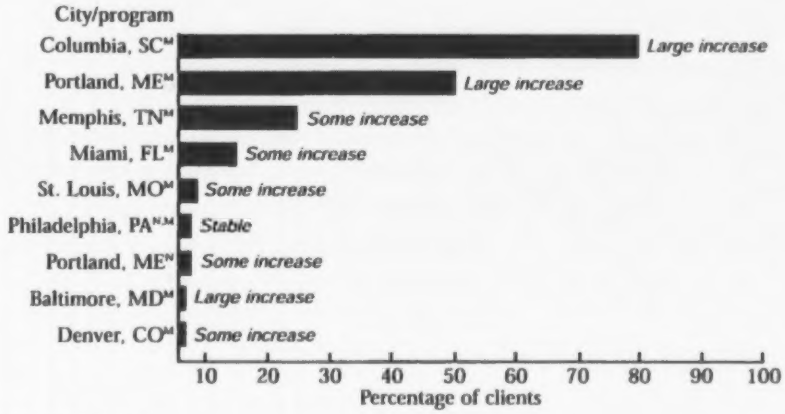
Getting the drug directly from pharmacies via forged prescription is also mentioned in the South: in Columbia (SC) and Memphis. In Memphis, however, some of the pills obtained in that manner are also sold on the black market. "Pill houses," or residences where drugs can be obtained, are mentioned in Columbia. In New Orleans, dealers use any means at hand, including cell phones, pagers, private introductions, and hand-to-hand street sales, thereby necessitating multiple disruption strategies. Hand-to-hand transactions predominate in Washington, DC's open-air markets. In the West, hand-to-hand sales and acquaintance networks are reported in Billings. In Honolulu's open-air markets, buyers know who the sellers are. In Los Angeles, some people obtain the drug via message boards on the Internet.

OXYCONTIN®: THE ABUSERS

How many OxyContin® abusers are in treatment? *(Exhibit 4)* OxyContin® is the primary drug of abuse among substantial percentages of clients in several treatment programs in *Pulse Check* sites, particularly in the Columbia (SC) and Portland (ME) methadone programs. It accounts for even higher percentages of clients who report any use (either

Exhibit 4.

Which treatment programs in *Pulse Check* sites have substantial percentages* of clients reporting OxyContin® as their primary drug of abuse? How have those percentages changed (fall 2001 vs spring 2002)?



** 4 percent or more*
Sources: Non-methadone and methadone treatment respondents

primary, secondary, or tertiary) in several cities, such as Miami^{M} (40 percent), St. Louis^{M} (15 percent), Boston^{N} (8 percent), Los Angeles^{M} (4 percent), and—most dramatically—in Memphis^{M}, where all 300 clients in the program report some use of the drug.

Since the last reporting period, among the treatment programs where abuse of this drug is reported, the number of users has increased substantially in 3, increased somewhat in 16, and remained stable in 10. Additionally, in El Paso, more users of OxyContin® are coming into detox. Those individuals, however, obtain the drug via legal prescriptions. While no treatment sources report declines, the epidemiologic sources in Miami and Washington, DC, do note slight declines in the number of abusers. In Miami, abusers are now more likely to use other types of legal and illegal narcotics, such as heroin, hydrocodone (Vicodin®), or methadone.

Who abuses OxyContin®? In Pulse Check cities where the drug is abused, the majority of treatment and epidemiologic/ethnographic sources report that adults older than 30 are the predominant abusers. More than one-third of those sources, however, name young adults (18–30 years) as such, and sources in Columbia (SC)N and Sioux FallsE name adolescents. Young adults are reported as an emerging group in nine cities, and adolescents are emerging as a user group in Boston, where the ethnographic source notes that younger siblings of older users are increasingly mixing these pills with alcohol. The Boston non-methadone treatment source adds that youngsters steal the pills from their parents, that they sometimes use guns to obtain the pills from pharmacies, and that they are increasingly involved in overdoses because they don't realize how powerful the drug is, so they take more than one at a time. Eleven sources provided mean ages, for an average of 33.6 years across sites.

About half of the sources report that males are the predominant abusers, about one-third of them report males and females as equally likely to abuse the drug, and sources in four cities—Denver^{M}, St. Louis^{M}, Seattle^{N,M}, and Sioux Falls^{E}—report that females predominate. Whites predominate in most cities, while low and middle socioeconomic groups are reported about equally.

Abusers reside predominantly in central city areas, according to treatment and epidemiologic/ethnographic sources in 10 of the *Pulse Check* cities—again, dispelling the myth of "hillbilly heroin." The suburbs are reported as the predominant residence in seven cities. All three geographic locations (central city, suburban, and rural) are reported in Columbia (SC), New Orleans, and Portland (ME); both central city and rural areas are reported in another three cities; and both central city and suburban areas are reported in another three.

Availability is down, but use and consequences are up...

- **Portland, ME^{E}**: People continue to be introduced to diverted OxyContin® despite lower availability, possibly because they consider it a "higher class" than heroin, which is a more "dirty drug."
- **Philadelphia, PA^{E}**: While availability is reported as either down^{L} or stable^{E}, mortality and emergency department episodes involving the drug have increased dramatically.

How is OxyContin® taken? Oral use remains the most common route of administration, according to treatment and epidemiologic/ethnographic sources in 13 cities. Injection, however, is reported by sources in four cities (Baltimore[E], Columbia [SC][M], Honolulu[E], and Washington, DC[E]), while both injecting and oral use are equally likely according to sources in another four (Billings[N,M], Honolulu[M], Miami[N,M], and Seattle[E]). Snorting is the predominant route of administration according to sources in Detroit[E], Memphis[M], and Portland (ME)[N,M], while both snorting and oral use are equally likely in Philadelphia[M]. All three routes of administration are equally likely in the Portland methadone program.

OxyContin® and heroin continue to be used as substitutes for one another, as mentioned in Baltimore[E], Honolulu[M], Miami[E], Philadelphia[N], Portland[E,N], and St. Louis[M]. The two are also sometimes taken sequentially, as reported in Miami[E] and Philadelphia[E]. In Miami, some heroin users, primarily younger Black injectors, are switching to OxyContin®, hydrocodone, and methadone.

OxyContin® abusers also frequently take other synthetic opioids, such as hydrocodone, hydromorphone (Dilaudid®), and other forms of oxycodone (Percodan® and Percocet®)—either as substitutes or in combination—as mentioned in Boston[E,M], Columbia[E], El Paso[M], Miami[E], Philadelphia[E], and St. Louis[N]. In Boston, many users are switching their primary drug of abuse from Percocet® to OxyContin®.

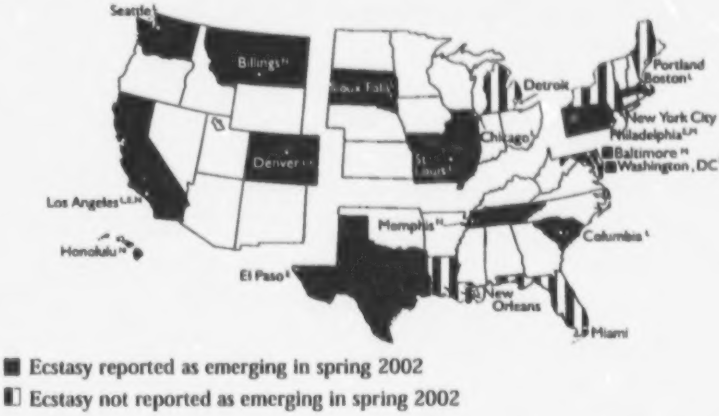
Benzodiazepines, such as alprazolam (Xanax®) and diazepam, are taken by OxyContin® abusers in several cities: as a substitute in Boston[M]; sequentially in Memphis[M] and Philadelphia[E,N]; and in combination in Columbia[M].

Alcohol, marijuana, or both are sometimes taken sequentially with OxyContin®, as reported in Billings[N], Boston[N], Memphis[E,M], Philadelphia[E,N], and Seattle[N]. Crack is taken sequentially with the drug in Philadelphia[E], and methamphetamine is taken either sequentially or as a substitute in Billings[N].

"ECSTASY" (METHYLENEDIOXYMETHAMPHETAMINE OR MDMA)[+]

Ecstasy is emerging, or continuing to emerge, as a drug of abuse in all but five *Pulse Check* cities: Detroit, Miami, New Orleans, New York, and Portland *(Exhibit 1)*. However, it has been reported as emerging in those five cities during previous reporting *Pulse Check* periods, suggesting it has either leveled off or—as is likely the case in Miami and New York—is now an established drug of abuse.

Exhibit 1.
Where is ecstasy emerging across the 20 Pulse Check cities?

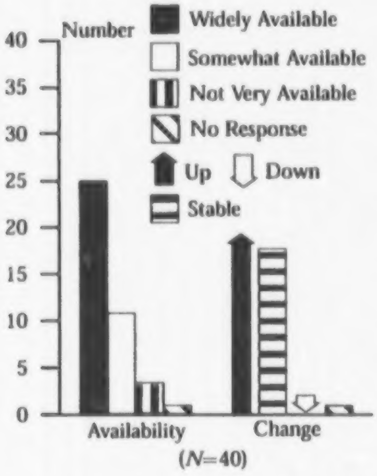

Seattle
Billings^{N}
Sioux Falls
Denver
St. Louis
Detroit
Chicago
Portland
Boston^{L}
New York City
Philadelphia^{L,M}
Baltimore^{N}
Washington, DC^{L}
Los Angeles^{L,E,N}
Honolulu^{N}
Memphis^{N}
Columbia^{L}
El Paso^{L}
New Orleans
Miami
■ Ecstasy reported as emerging in spring 2002
◧ Ecstasy not reported as emerging in spring 2002

ECSTASY: THE DRUG

How available is ecstasy in *Pulse Check* communities? *(Exhibit 2)*

Ecstasy, typically in pill form, is considered widely available by the majority (25) of the 40 law enforcement and epidemiologic/ethnographic sources. Only three sources consider it not very available: in Billings^{E}, El Paso^{L}, and Sioux Falls^{L}. The remainder consider it somewhat available.

Exhibit 2.
How available is ecstasy, and how has availability changed, across the 20 Pulse Check cities (fall 2001 vs spring 2002)?



Sources: Law enforcement and epidemiologic/ethnographic respondents

Since the last reporting period, about half of the responding law enforcement and epidemiologic/ethnographic sources report that ecstasy availability has increased, and approximately half report that it has remained stable, often at elevated levels. Only two report declines: in Miami^{E} and Sioux Falls^{L}.

How is ecstasy referred to across the country, and how are logos and packaging used as marketing tools? *(Exhibit 3)*

In order to market their product, "cooks" in many areas produce ecstasy pills in a variety of colors and shapes, with numerous logos, labels, and stamps. Corporate names, fashion designers, and cartoon characters are often featured, with constant changes in some cities as different fads come and go. Many users derive their slang terminology from these logos, labels, and shapes. "X," however, remains the most common slang name for ecstasy, as reported in nearly every *Pulse Check* site. "E" is also common, as are "roll" and "XTC."

As reported in past *Pulse Checks*, tablets continue to be sold predominantly as loose pills. Additionally, pills are sometimes packaged in small plastic bags, plastic prescription bottles, plastic wrap, folded paper, coin bags, and tinfoil. Cigarette packs, a more unusual packaging, are reported in St. Louis. Some large-quantity packaging is reported: in Detroit, a "jar" contains 3,200 pills; in Denver, up to 20,000 pills are heat-sealed in plastic and strapped to the body.

[+] *The following symbols appear throughout this chapter to indicate type of respondent: ^{L}Law enforcement respondent, ^{E}Epidemiologic/ethnographic respondent, ^{N}Non-methadone treatment respondent, and ^{M}Methadone treatment respondent.*

Exhibit 3.
How is ecstasy referred to and marketed across the 20 *Pulse Check* cities?*

	City	Slang terms	Marketing labels, logos, colors, shapes
Northeast	Boston, MA	X, MDMA, adam, essence, flipping, rolling	Logos: bulldog, calvin klein, hearts, lightning, mcdonalds, nikes, playboy, tulips, yin and yang signs, many more
	New York, NY	NR	Yes (but names unavailable)
	Philadelphia, PA	E	None
	Portland, ME	X, E, pure X, roll	NR
South	Baltimore, MD	X, E, essence, eve, lovers, speed	None
	Columbia, SC	E, four-leaf-clover, rolls, S, smurfs	Tablets of all colors Logos: balloons, cartoon characters, diamonds
	El Paso, TX	E, tachas	Red pill with E
	Memphis, TN	X, XTC, adam, beans, clarity, lover's special, rolls, stacks, double stacks, tabs	None
	Miami, FL	X, E, beans, mercedes, rolls, roll X	All kinds, change often
	New Orleans, LA	X, XTC, pill, tabs	None
	Washington, DC	X, E, igloo, mercedes, pikachu, pills, rolls	Different colors, round shape; E, animals, igloo, mercedes, pikachu, pills, rolls
Midwest	Chicago, IL	X, E, rolls	Cartoon stamps Logos: CK (for calvin klein), mitsubishi, motorola, other corporate names and fashion brand names
	Detroit, MI	X, E	Logos vary widely
	Sioux Falls, SD	X, E, roll, snackies (more mescaline based), speedies (more amphetamine based)	Logos: elephants, mitsubishi, nike, sun face
	St. Louis, MO	X, E, XTC, candy, rolls, shamrock, tabs	Proliferation of logos
West	Billings, MT	Peace, serenity, **tranquility**	None
	Denver, CO	X, E, adam, the bean, pills, rolls, **tabs, wafers**	Batman, jimmy neutron, many more (change continually)
	Honolulu, HI	X, E	None
	Los Angeles, CA	Love drug	Logos: blue dolphin, calvin klein, dove, blue smile, ferarri, green apple, mitsubishi
	Seattle, WA	X, E	Logos: mcdonalds, mitsubishi, yin-yang

**Bolded names are new since the last reporting period.*
Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

What substances are added to or sold as ecstasy? During this reporting period, fewer sources report adulterated ecstasy than in the last *Pulse Check*. Reported adulterants include mescaline and methamphetamine in Memphis, and codeine, dextromethorphan (DXM), and paramethoxyamphetamine (PMA) in Los Angeles. Mescaline, previously reported in Sioux Falls, has not been seen there in the past year. In Seattle, adulterants are less toxic than those reported in the last *Pulse Check*. Fraud is now more common there: for example, one batch of confiscated "ecstasy" actually consisted of hormone replacement pills. Fraudulent substitutions are also reported in Detroit and St. Louis. According to the New York non-methadone treatment source, most clients in the program "fully believe that the drug is a mix of cocaine and something else." In the Miami area, the medical examiner recently detected 147 "methylated amphetamine compounds"—substances sold as ecstasy—in decedents.

What are street-level ecstasy prices across the country? *(Exhibit 4)* Pill prices range from lows of $5 in El Paso and $7 in New Orleans to a high of $100 in St. Louis, but the most common prices are about $20–$25. In New York, ecstasy is cheaper on the street than in clubs. Conversely, in Seattle, prices are lower at raves than in the community. Prices appear relatively stable since the last reporting period. The only reported changes are an increase in New York[E] and declines in Philadelphia[E] and Miami[L]. Reduced-price sales in Miami are at the single-pill and 100-pill level, paralleling a shift in user demographics. The high profit margin is an incentive for users to sell ecstasy at clubs, raves, and to friends. Once these young user-dealers cover their costs, unlike the more

Exhibit 4.
How much does a pill (one dose) of ecstasy cost in the 20 Pulse Check cities?

	City	Price
Northeast	Boston, MA^{L}	\$20–\$25
	Boston, MA^{E}	\$25
	New York, NY^{L}	\$25–\$38
	New York, NY^{E}	\$15–\$25 (street) \$25–\$35 (clubs)
	Philadelphia, PA^{L}	\$20–\$35
	Philadelphia, PA^{E}	\$15–\$20
	Portland, ME^{L}	\$25
South	Baltimore, MD^{L}	\$18–\$20
	Columbia, SC^{L}	\$25–\$30
	El Paso, TX^{L}	\$20
	El Paso, TX^{E}	\$5–\$8
	Memphis, TN^{L}	\$20
	Memphis, TN^{E}	\$25
	Miami, FL^{L}	\$11–\$18
	New Orleans, LA^{L}	\$7
	Washington, DC^{L}	\$18–\$25
	Washington, DC^{E}	\$20–\$35
Midwest	Chicago, IL^{L}	\$25
	Chicago, IL^{E}	\$20–\$40
	Detroit, MI^{L,E}	\$20–\$30
	St. Louis, MO^{L}	\$100
	St. Louis, MO^{E}	\$20–\$30
	Sioux Falls, SD^{L}	\$30–\$50
West	Billings, MT^{L}	\$25
	Denver, CO^{L}	\$25
	Denver, CO^{E}	\$10–\$20
	Honolulu, HI^{L}	\$25–\$45
	Honolulu, HI^{E}	\$17–\$40
	Los Angeles, CA^{E}	\$25–\$40
	Seattle, WA^{L,E}	\$10–\$20 (raves) \$20–\$30 (street)

Profit by the pill...

Los Angeles provides an example of ecstasy's high profit potential:

- A wholesale-level dealer pays \$8 per pill (a "boat" of 1,000 pills for \$8,000).
- The pills are sold to mid-level and then low-level dealers.
- The user pays up to \$40 per pill.

organized wholesale-level dealers, they keep the leftovers as a personal "stash," sell to friends at discount, or even give them away. High profits are also evident in Los Angeles.

ECSTASY: THE MARKET

Who sells ecstasy? As reported in previous *Pulse Checks*, young adults (18–30 years) continue to be the predominant street-level ecstasy sellers, according to the majority of responding law enforcement and epidemiologic/ethnographic sources. However, sources in Baltimore, Detroit, Honolulu, Los Angeles, Memphis, and St. Louis report ecstasy sellers as evenly split between young adults and adolescents. Moreover, sources in El Paso, New Orleans, and Seattle report sellers as primarily adolescents. Only one source in Baltimore reports adults older than 30 as the predominant sellers.

Ecstasy sellers continue to be predominantly independent, according to the majority of responding law enforcement and epidemiologic/ethnographic sources. Both independent and organized sellers are reported in El Paso, Miami, and Portland (ME).

Nearly all respondents believe that sellers are very likely or somewhat likely to use their own ecstasy (*see Highlights Exhibit 8*). Only one (Miami^{E}) believes that sellers are not very likely to use it. Sellers in Memphis are more likely to use than last year. In Denver, adolescents tend to sell single pills and to use themselves, while adults (25–35 years) sell larger quantities and do not typically use.

Are ecstasy sellers involved in other crimes? As reported in the past, street-level ecstasy sellers are not typically involved in other crimes or violence. Among those who are, the most common crime continues to be drug-assisted rape, reported in nine cities: Columbia (SC)^{L}, Denver^{L}, Detroit^{L} , Honolulu^{L}, Los Angeles^{L}, Memphis^{L}, New Orleans^{L}, New York^{E}, and Sioux Falls^{L}. Nonviolent crime is reported in eight cities: Billings^{L}, Detroit^{L}, El Paso^{L,E}, Honolulu^{L}, Los Angeles^{L}, Memphis^{E}, St. Louis^{E}, and Sioux Falls^{L}. Two examples of nonviolent crimes are tagging and vandalism in El Paso, and petty theft and shoplifting in St. Louis.

Where are ecstasy markets located? Ecstasy sales span all geographic areas:

- All three types of areas (central city, suburban, and rural) are reported in half of the *Pulse Check* cities: Baltimore^{L}, Columbia (SC)^{L}, Memphis^{L}, Miami^{E}, New York^{L}, Philadelphia^{L}, Portland (ME)^{L}, and Washington, DC^{L}.
- Central city market locations are more prominent in Billings^{L}, Honolulu^{L}, New York^{E}, New Orleans^{L}, and Washington, DC^{E}.
- Central city and suburban locations are equally common in Baltimore^{E}, Chicago^{E}, Denver^{E}, Honolulu^{E}, Los Angeles^{L}, Memphis^{E}, St. Louis^{L}, and Seattle^{L}.
- Suburban areas are the primary market sites in Boston^{L}, Detroit^{E}, El Paso^{L,E}, Miami^{L}, St. Louis^{E}, and Sioux Falls^{L}.

Whereas markets for drugs like heroin and cocaine are increasingly moving indoors in some cities, the ecstasy market is continuing to move outdoors. Disrupting the market therefore requires new and broader strategies. More than half of responding law enforcement and epidemiologic/ethnographic sources now report that ecstasy is sold both indoors and outdoors: Baltimore^{L}, Billings^{L}, Columbia^{L}, Denver^{L}, El Paso^{L}, Honolulu^{L,E}, Memphis^{E}, Miami^{L,E}, New York^{L}, Philadelphia[L], Portland (ME)[L], St. Louis[E], and Sioux Falls[L]. One source (El Paso[E]) reports only outdoor sales. Elsewhere, the drug is still sold primarily indoors.

The most commonly reported indoor market locations, according to law enforcement sources, are still raves and concerts (reported in nearly every *Pulse Check* city), followed (in descending order of report frequency) by nightclubs and bars, college campuses, parties, private residences, schools, cars, hotels or motels, and the Internet.

How is ecstasy sold? Ecstasy sales are often venue oriented and usually involve acquaintance networks or private introductions to sellers. Hand-to-hand exchanges are common. In some cities, sellers approach buyers or buyers approach sellers, as reported in Honolulu, Philadelphia, Portland (ME), Seattle, Sioux Falls, and Washington, DC. Beepers and cell phones are mentioned in only five cities (Columbia [SC], Los Angeles, New Orleans, St. Louis, and Sioux Falls), and prearranged meetings are mentioned in only two (Chicago and Memphis). In Chicago, hawkers walk around in semipublic settings, such as nightclubs and raves, announcing "caps" or "rolls," while in Seattle buyers know who to ask for at the door, and that person directs them to the sellers. By contrast, in Boston, most drugs are sold before users enter clubs.

What other drugs do ecstasy dealers sell? Law enforcement and epidemiologic/ethnographic sources in nine *Pulse Check* cities report that ecstasy sellers do not typically sell other drugs. In the other cities, the most common other drugs sold, as reported in the last *Pulse Check*, are club drugs, including GHB, ketamine, and, to a lesser extent, LSD. Marijuana is sold by ecstasy dealers in nearly half the *Pulse Check* cities (Baltimore, Billings, Denver, El Paso, Miami, Philadelphia, Portland, Seattle, and Sioux Falls), methamphetamine in four cities (Billings, Denver, Philadelphia, and Washington, DC), powder cocaine in another four cities (Baltimore, Columbia [SC], Miami, and Philadelphia), crack in three (Baltimore, Denver, and Washington, DC), and other pills, typically benzodiazepines and opiates, in Memphis and Philadelphia.

The ecstasy market has changed somewhat (fall 2001 vs spring 2002)....

New marketing strategies include changing pill colors, shapes, logos, and labels:	➤ **Columbia, SC[L]**: Pills come in more colors than during the last reporting period. Home-pressed pills are no longer seen, nor are mercedes or elephant logos. ➤ **Denver, CO[L]**: Logos and labeling are constantly changing, depending on the latest fads. ➤ **St. Louis, MO[E]**: An increase in logos reflects the proliferation of pills, many of which are really contaminants. ➤ **Seattle, WA[L]**: Pills now come in blue and orange, not just white as in the past—reflecting an increase in availability and variety of pills and a broadening in the number and creativity of domestic cooks.
New trafficking techniques are reported:	➤ **Miami, FL[E]**: Body packing of ecstasy from Canada has increased. Some smuggling by cruise ship passengers is reported.
Markets continue spreading beyond the club and rave scenes:	➤ **Chicago, IL[L]**: Ecstasy is being seen on the street for the first time. ➤ **New York, NY[E]**: Ecstasy continues to spread outside of raves, especially on the streets and in buildings, particularly in The Bronx and Staten Island. ➤ **St. Louis, MO[E]**. Once associated only with raves inside the city, ecstasy has now moved to high schools and colleges in suburban areas and might eventually reach rural schools. ➤ **Seattle, WA[L,E]**: Ecstasy has "jumped out of the pack of other party drugs" and is hitting schools and the streets: "Every kid in school knows someone who can get it."
More adolescents and young adults are selling ecstasy in some cities:	➤ **Miami, FL[L]**: Young adults continue to be more involved, especially via connections in high schools. ➤ **Los Angeles, CA[L]**: More adolescents are selling than in the past. ➤ **Seattle, WA[L]**: More young adults are actively involved.
Some new seller groups are reported:	➤ **Philadelphia, PA[L]**: New organized Russian and Israeli groups are reported. ➤ **Portland, ME[L]**: Occasional organized groups of out-of-State promoters are becoming more frequent. ➤ **Washington, DC[E]**: Club owners, bartenders, and bouncers are increasingly allowing people to sell ecstasy on their premises.

ECSTASY: THE USERS

How many ecstasy users are in treatment? Despite ecstasy's increasing involvement in mortality and emergency department episodes in many cities, clients in treatment generally do not report ecstasy as a primary drug of abuse. Further, only a handful of *Pulse Check* treatment sources report that clients in their programs use it as a secondary or tertiary drug: Seattle[N] (10 percent); Philadelphia[M] (8 percent); Baltimore[M] (<5 percent); Miami[N] (4 percent); and Portland[N] (4 percent). However, slight increases are reported in all those programs, as well as in other programs where the numbers are lower.

Some theories about why ecstasy numbers in treatment appear low...

- ➤ **Columbia, SC**[E]: "The numbers are small and probably underestimated because they don't seek treatment."
- ➤ **Memphis, TN**[N]: "The drug is not in the program because we serve mostly adults. But the problem is rising in the community, especially among adolescents at parties. I anticipate seeing more young adults showing up in the future."
- ➤ **Los Angeles, CA**[E]: "Ecstasy is slower to show up in indicators than other drugs because people are not always asked about it."
- ➤ **New York, NY**[M]: "The program doesn't test for it (ecstasy). It's generally not seen in this older chronic 'doper' population."

Who uses ecstasy? Ecstasy users tend to be young adults (18–30 years), particularly according to epidemiologic/ethnographic sources. However, several non-methadone sources believe that adolescents are the primary user group (in Billings, Columbia, Portland, Seattle, and Sioux Falls), while several sources, both among epidemiologists/ethnographers and treatment providers, believe that young adults and adolescents are equally likely to use the drug. As reported in past *Pulse Checks*, ecstasy users tend to be evenly split between the genders (*see Crack Exhibit 6*). Also as reported previously, Whites predominate as ecstasy users in nearly all cities. Hispanics are named as the primary user group in only two cities (Los Angeles[N] and Miami[N]), as are Blacks (in Baltimore[E,M] and Washington, DC[N]). All three groups appear equally represented in New York[E]. Whites and Asians are equally likely to use ecstasy in Honolulu[E]. In Los Angeles, three distinct user groups are reported: the "ravers," who tend to be White, followed by the "hip-hop crowd," who are generally Black, and then the gay circuit partygoers.

Ecstasy users tend to come from middle socioeconomic backgrounds. However, low socioeconomic groups are mentioned as predominant in Baltimore[E,M], Billings[N], Chicago[N], Los Angeles[N], and Philadelphia[M], while high socioeconomic groups are mentioned in Denver[E], Detroit[E], Honolulu[E], Los Angeles[E], Miami[N], St. Louis[E], Sioux Falls[E], and Washington, DC[E]. The suburbs are mentioned slightly more often than the central city as the area where ecstasy users are most likely to live.

Where do users take ecstasy? As reported in past *Pulse Checks*, nearly all epidemiologic/ethnographic and treatment sources report that ecstasy is used predominantly in groups or among friends. It is equally likely to be used in public and private settings, most typically (in descending order of report frequency, with 10 or more reports each) at raves, private parties, nightclubs or bars, private residences, and college campuses. In some cities, ecstasy is sold but not used in specific settings: the most frequent instances are high schools (as in Chicago, Detroit, Honolulu, and Miami), the streets (as in El Paso, Miami, and New York), and in or around malls (as in El Paso, Miami, and New York). Conversely, ecstasy is used but not sold at parties and raves in Sioux Falls.

How and with what other drugs is ecstasy taken? Ecstasy tablets are almost always consumed orally, as reported in past *Pulse Checks*. Exceptions, however, are occasionally reported. In Boston, for example, some users in their late teens and early twenties inject ecstasy and ketamine intramuscularly. In Sioux Falls, an increasing number of users report crushing and snorting ecstasy.

Ecstasy continues to be taken, either in combination with or sequentially, with alcohol, marijuana, or both. It is also taken with an array other substances, both legal and illegal:

- ■ **LSD**: Boston, Chicago, Denver, Los Angeles, and St. Louis
- ■ **GHB**: Boston, Miami, Los Angeles, and Sioux Falls
- ■ **Ketamine**: Boston, Denver, El Paso, and Los Angeles
- ■ **Prescription pills (benzodiazepines or antidepressants)**: Los Angeles, Memphis, and Miami
- ■ **Heroin**: New York and Philadelphia
- ■ **Cough syrup**: Philadelphia
- ■ **Camphor/menthol inhalants**: Memphis
- ■ **Sildenafil (Viagra®)**: Miami and St. Louis
- ■ **Nitrous oxide**: Chicago

The changing nature of ecstasy users and use patterns (fall 2001 vs spring 2002)...

Younger students are using ecstasy in some cities:	➤ **Baltimore, MD**^{E}: Anecdotal evidence is increasing about ecstasy use in middle schools. ➤ **Boston, MA**^{E}: Ecstasy use is increasing slowly but steadily among minority high school students. Additionally, it is increasing among students in private schools.
Increasing use is reported among some minorities and socioeconomic groups:	➤ **Memphis, TN**^{E}: Since the last reporting period, socioeconomic status has been shifting from high to middle. ➤ **New York, NY**^{E}: Blacks are increasingly using ecstasy, and Hispanics are a growing market for street ecstasy. ➤ **St. Louis, MO**^{N}: Blacks continue to increase as an ecstasy-using population. ➤ **Sioux Falls, SD**^{N}: More American Indians are using ecstasy.
Use is increasing in some rural areas:	➤ **El Paso, TX**^{E}: Ecstasy use, which had been limited to warehouses in the central city, has moved further out into rural areas—largely because police have moved the users out. ➤ **St. Louis, MO**^{E}: A growing number of rural residents are coming into the city to buy ecstasy. ➤ **Sioux Falls, SD**^{N}: American Indians are increasingly using ecstasy on rural reservations.
Some use settings are shifting:	➤ **Baltimore, MD**^{E}: Ecstasy is increasingly used on the street. ➤ **El Paso, TX**^{E}: In addition to the new raves in rural areas, raves of 200–300 adolescents at a time are taking place clandestinely at night on unpoliced, unlit golf courses within the city. Ravers, who can easily disperse, find each other by using laser pointers or by putting "glow sticks" around their wrists and necks. ➤ **Los Angeles, CA**^{E}: Ecstasy use is becoming more prevalent in private settings, such as residences and parties. It is not just a club drug anymore. ➤ **St. Louis, MO**^{E}: Ecstasy is increasingly used while alone, not just in groups and among friends, as in the past.
Some drug combinations have changed:	➤ **El Paso, TX**^{E}: Ketamine use with ecstasy is a new phenomenon. ➤ **Miami, FL**^{L}: Since September 11, more combinations—although fewer cases—have been reported. Also, LSD use is less reported than in the past. ➤ **Sioux Falls, SD**^{N}: Marijuana use with ecstasy is increasing.

OTHER DRUGS OF CONCERN[+]

This round of *Pulse Check* discussions focused on the illicit or illicitly used drugs described in the previous chapters: heroin, crack cocaine, powder cocaine, marijuana, methamphetamine, diverted synthetic opioids, and ecstasy. During the course of these discussions, however, sources sometimes mentioned other drugs of concern in their communities.

BENZODIAZEPINES

- Benzodiazepines are mentioned as an emerging drug problem in Boston^{E}. Alprazolam (Xanax®) and clonazepam (Klonopin®), in particular, are widely abused in Boston methadone programs.
- Benzodiazepines are considered the drugs with the most serious consequences by methadone treatment sources in Baltimore, Honolulu (where they have replaced heroin since the last reporting period), Memphis, and Miami.
- In general, alprazolam is the most frequently mentioned benzodiazepine.
- Benzodiazepine use has increased in Memphis^{E}, especially among White adult females in rural areas. Dealers are reported as older and more rural than in the past. Alprazolam is particularly common among methadone clients.
- Benzodiazepine abuse has increased somewhat among methadone treatment clients in St. Louis.
- High school students in Miami are increasingly abusing alprazolam, sometimes with ecstasy, sometimes by itself.

CLONIDINE (Catapres®)

- Abuse of clonidine, often prescribed for high blood pressure, is mentioned as an emerging drug problem in Baltimore^{M}.
- The drug is sold on the streets in New York.

DEXTROMETHORPHAN (DXM)

- Dextromethorphan abuse is reported as an emerging problem in Denver.
- Treatment clients in Sioux Falls^{N} are increasingly abusing over-the-counter preparations containing DXM, taking 15 or more pills at a time.
- Abuse of such over-the-counter preparations has also increased somewhat in Detroit.

FLUNITRAZEPAM (Rohypnol®, or "roches")

- Once commonly referred to as "the date rape drug" in many States, epidemiologic, legislative, and law enforcement efforts have paid off. The only *Pulse Check* sources to mention the drug as an ongoing problem are in El Paso, where it accounts for substantial percentages of treatment admissions.
- In El Paso, the drug continues to be involved in prostitution, gang-related activity, violent and nonviolent crime, domestic violence, and drug rape.
- The El Paso epidemiologic source notes two changes: users are now selling their product; and, with the aging of the population, more adults older than 30 are involved in sales and use.

GHB (gamma hydroxybutyrate)

- GHB is mentioned as an emerging problem in Denver and Los Angeles.
- The drug is reported as widely available in Denver^{E}, Los Angeles^{L}, Miami^{L}, and New Orleans^{L}. Availability has increased in Los Angeles^{L,E}, Memphis^{L}, and Sioux Falls^{L}. It has declined in Miami^{E} and St. Louis^{L,E}.
- Almost anyone can produce GHB because precursors and recipes are available on the Internet.
- Like ecstasy, it is often associated with the club or rave scene.
- GHB sellers tend to be young adults who operate independently and are somewhat likely to use their own drug.
- Some epidemiologic/ethnographic sources note GHB sellers' involvement in different types of crime: drug rape (in Los Angeles, Memphis, St. Louis, and Sioux Falls), other violent crimes (in Memphis, New Orleans, and Washington, DC), nonviolent crimes (in Detroit, Memphis, and Sioux Falls), domestic violence (in Memphis), and gang-related activity (in Memphis and New Orleans).

[+] The following symbols appear throughout this chapter to indicate type of respondent: ^{L}Law enforcement respondent, ^{E}Epidemiologic/ethnographic respondent, ^{N}Non-methadone treatment respondent, and ^{M}Methadone treatment respondent.

What are some street prices of other drugs of concern?

Drug	City	Most common unit sold	Price
GHB	Chicago, IL[L]	Dosage unit	$5
	Denver, CO[L]	Capful (5 ml)	$5-$20
	Los Angeles, CA[L]	Capful	$20
	Miami, FL[L]	Dosage unit	$10
	New Orleans, LA[L]	Dosage unit	$5-$20
	St. Louis, MO[E]	Capful	$5
		1 oz	$40
	Seattle, WA[L]	100 dosage units	$100
Ketamine	Boston, MA[L]	Bottle (1 oz)	$50
	Columbia, SC[L]	Vial (2 oz)	$125
	Philadelphia, PA[L]	Vial	$10-$20
Rohypnol	El Paso, TX[L]	Pill (2 mg)	$2
LSD	Philadelphia, PA[L]	Tab	$3-$5
	Seattle, WA[L]	Dose	$5
PCP	Honolulu, HI[E]	3 g	$10-$20
	Philadelphia, PA[E]	Liquid or leaves	$5
	St. Louis, MO[E]	Fluid oz	$350
	Washington, DC[L]	1 oz	$350-$500
		"love boat" (marijuana = 700-800 mg PCP)	$40

KETAMINE ("special K")

- Ketamine is reported as an emerging or intensifying drug problem during this period in Denver, El Paso, New Orleans, and Sioux Falls. It is increasingly available in Memphis.
- The drug is sometimes associated with the club or rave scene.
- Like GHB sellers, ketamine sellers tend to be young adults who operate independently and are somewhat likely to use their own drug.
- Ketamine is sometimes stolen from veterinarian offices, as reported in New Orleans[L].

KHAT

- A natural stimulant from the Catha Edulis plant, khat is found in a flowering evergreen tree or large shrub from East Africa and Southern Arabia. Its leaves contain psychoactive ingredients structurally and chemically similar to d-amphetamine.
- Khat leaves are widely available in Boston, and availability continues to increase with the continued growth in east African populations who abuse the substance.

LSD (lysergic acid diathylamide)

- No sources report LSD as widely available.
- One source (Miami[E]) notes that a supply is no longer seen because people don't seek out the drug.

PCP (phencyclidine hydrochloride)

- PCP is reported as an emerging problem in Philadelphia and Washington, DC.
- Availability is up in Baltimore, particularly in more rural areas, where the drug is sometimes mixed with crack.

SILDENAFIL (Viagra®)

- Many counterfeit pharmaceutical tablets, particularly sildenafil, continue to be illegally distributed over the Internet. Many of these products contain adulterants.
- In Miami, sildenafil continues to be used together with ecstasy (a combination known as "sextasy" and a practice called "hammerheading") or with methamphetamine ("tina").

APPENDIX 1: METHODOLOGY

How were the sites selected? *(See map in the Introduction)* A total of 20 sites were studied for this issue of *Pulse Check*. During 2000, we selected sites using Census Bureau regions and divisions with a goal of achieving geographic and demographic diversity. In addition, we made an effort to select sites in areas with special drug abuse problems of national concern. More specifically, we applied the following methodology in selecting sites.

We purposely selected the most populous States in the four census regions: New York in Region I (Northeast Region); Texas in Region II (South Region); Illinois in Region III (Midwest Region); and California in Region IV (West Region). In three of these States, we selected the most populous metropolitan areas: New York City, Chicago, and Los Angeles. In Texas, however, we selected El Paso—a known high trafficking area with particularly high levels of unemployment, population growth, and poverty—because of its proximity to the United States border with Mexico.

We included four rural States, one per census region. (Rural States are defined by the Census Bureau as those in which 50 percent or more of the State's population reside in census-designated rural areas.) The four rural sites selected are as follows:

- Region I (Northeast): Portland, ME—Of the three rural States in the Northeast Region (including New Hampshire and Vermont), Maine has the only Atlantic coastline and shares the longest border with Canada. It also includes an ONDCP-designated High Intensity Drug Trafficking Area (HIDTA). Portland is Maine's most populous metropolitan area.
- Region II (South): Columbia, SC—The three other rural States in the South census region are Kentucky, Mississippi, and West Virginia. However, South Carolina's location along a major drug trafficking corridor makes that State a strategic choice. Recent cocaine seizures in Columbia further highlight its strategic importance.
- Region III (Midwest): Sioux Falls, SD—Sioux Falls is the most populous metropolitan area within the Midwest Region's two rural States (North Dakota and South Dakota).
- Region IV (West): Billings, MT—Montana is the only census-designated rural State in the West Region, and Billings is its most populous metropolitan area.

The remaining 12 sites were selected to ensure that the entire list included at least 2 sites from each of the 9 Census Bureau divisions (East North Central, Mountain, Middle Atlantic, New England, Pacific, South Atlantic, South East Central, South West Central, and West North Central). Additional selection criteria included population density, representation of racial/ethnic minorities, and emphasis on high drug trafficking areas.

Applying these criteria resulted in the final selection of the following 20 *Pulse Check* sites:

Baltimore, MD*
Billings, MT
Boston, MA
Chicago, IL
Columbia, SC
Denver, CO
Detroit, MI
El Paso, TX
Honolulu, HI
Los Angeles, CA
Miami, FL
Memphis, TN
New Orleans, LA
New York City, NY
Philadelphia, PA
Portland, ME
St. Louis, MO
Seattle, WA
Sioux Falls, SD
Washington, DC

How do the 20 sites vary demographically? Appendix 2 highlights the demographic diversity of these 20 sites. For example, their population density per square kilometer ranges from a sparse 18.6 in Billings, MT, to a crowded 2,931.6 in New York City. Their unemployment rates range from a 2.4 low in Sioux Falls, SD, to a 6.2 high in El Paso, TX. The racial/ethnic breakdowns in the 20 sites further exemplify their diversity: White representation ranges from 21.2 percent in Honolulu, HI, to 96.0 percent in Portland, ME; Black representation ranges from 0.4 percent in Billings, MT, to 43.2 percent in Memphis, TN; and Hispanic representation ranges from less than 1 percent in Portland, ME, to 78.3 percent in El Paso, TX.

**Because of concerns about its unique problems involving heroin and cocaine, Baltimore, MD, was added as a Pulse Check site for the report covering the January–June 2001 period; Birmingham, AL, was dropped as of the July–December 2001 issue in order to maintain balanced geographic representation.*

What other data are available at the 20 selected sites? Information from other national-level data sources will be useful for framing, comparing, corroborating, enhancing, or explaining the information obtained for *Pulse Check*. The following data sources are available in nearly every site: ONDCP's past *Pulse Check* reports; the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG); the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN); and the National Institute of Justice (NIJ) Arrestee Drug Abuse Monitoring (ADAM) program.

Who are the Pulse Check sources, and how were they selected? Consistent with previous issues, the information sources for *Pulse Check* were telephone discussions with 4 knowledgeable individuals in each of the 20 sites: 1 ethnographer or epidemiologist, 1 law enforcement official, and 2 treatment providers. Ethnographers and epidemiologists were recruited based on several possible criteria: past participation in the *Pulse Check* program; membership in NIDA's CEWG; research activities in local universities; or service in local community programs. We recruited law enforcement officials by contacting local police department narcotic units, Drug Enforcement Administration (DEA) local offices, and HIDTA directors. All but 2 of the 40 epidemiologists, ethnographers, and law enforcement sources who reported for this issue of *Pulse Check* were the same, or associated with the same agencies, as those who reported for the previous issue.

To identify treatment sources for the Mid-Year 2000 issue of *Pulse Check*, we randomly selected providers from the 1998 Uniform Facility Data Set (UFDS), a listing of Federal, State, local, and private facilities that offer drug abuse and alcoholism treatment services. For this purpose, we excluded facilities that reported more than 50 percent of their clientele as having a primary alcohol abuse problem, served a caseload of fewer than 100 clients, or provided only prevention or detox services. We then divided the remaining facilities into two groups—methadone and non-methadone treatment facilities—in order to capture two client populations whose demographic characteristics and use patterns often differ widely. We selected one from each of these two categories of programs for each of the 20 selected sites. Because Billings, MT, and Sioux Falls, SD, have no UFDS-listed methadone treatment facilities, we selected two non-methadone facilities in those sites.

Since the Mid-Year 2000 issue of *Pulse Check*, in order to preserve continuity, all actively available treatment sources have been retained. Additionally, to ensure regular reporting, any treatment provider who becomes unavailable to participate is being replaced via purposeful, rather than random, selection based on consultation with experts in the field. Altogether, we recruited 40 treatment sources: 18 methadone providers (1 from each *Pulse Check* site except for Billings and Sioux Falls, where methadone treatment is unavailable), and 22 non-methadone providers (1 from each *Pulse Check* site plus extra sources from Billings and Sioux Falls). Thus, a total of 80 sources have been identified and recruited, and for this *Pulse Check* issue we successfully obtained information from 78 of them: a response rate of 98 percent. Two participants were unavailable: one of the two the non-methadone treatment providers from Sioux Falls; and the methadone treatment provider from New Orleans.

What kind of data were collected, and how? For each of the 78 responding sources, we conducted a single telephone discussion lasting about 1 hour. We asked sources to explore with us their perceptions of the change in the drug abuse situation between fall 2001 and spring 2002. We discussed a broad range topic areas with these individuals, as delineated in Appendix 5. Not surprisingly, ethnographic and epidemiologic sources were very knowledgeable about users and patterns of use; they were somewhat knowledgeable about drug availability; and they were less informed about sellers, distribution, and trafficking patterns. Treatment providers had a similar range of knowledge, but they generally focused on the specific populations targeted by their programs. Some providers, however, were able to provide a broader perspective about the communities extending beyond their individual programs. Among the three *Pulse Check* source types, law enforcement officials appeared to be most knowledgeable about drug availability, trafficking patterns, seller characteristics, sales practices, and other local market activities; they were not asked to discuss user groups and characteristics.

APPENDICES 2 AND 3: SITE DEMOGRAPHICS AND OTHER DATA SOURCES

APPENDIX 2: POPULATION DEMOGRAPHICS IN THE 20 PULSE CHECK SITES

	Pulse Check Site	MSA Size* (S,M, L, X)*	Race Percent[a]				Percent Hispanic	Violent Crime/ 100,000 Population[b]	Percent Persons Under 18 Below Poverty Level[a]	Unemployment Rate[a]	Population Density/ Square KM[c]	Percent Urban[a]	Percent Rural[a]
			White	Black	American Indian/ Alaska Native	Asian/ Pacific Islander							
Northeast	Boston, MA-NH PMSA	L	82.5	6.8	0.2	4.9	5.9	505	2.3	3.3	353.3	96.3	3.7
	New York, NY PMSA	X	48.8	24.4	0.4	9.2	25.1	1,037	6.7	6.1	2,931.6	99.4	0.6
	Philadelphia, PA-NJ PMSA	X	72.2	20.0	0.2	3.4	5.0	667	3.8	4.6	495.7	94.8	5.2
	Portland, ME	S	96.0	0.9	0.4	1.2	0.8	730	2.3	2.9	368.7	68.2	31.8
South	Baltimore, MD PMSA	L	67.4	27.2	0.3	2.7	2.0	581	3.2	3.8	110.9	90.4	9.6
	Columbia, SC	M	63.9	32.0	0.4	1.5	2.5	868	3.9	4.1	136.8	78.8	21.2
	El Paso, TX	M	74.1	3.0	0.7	1.1	78.3	668	10.2	6.2	267.5	97.0	3.0
	Memphis, TN	L	52.9	43.2	0.2	1.5	2.3	1,081	6.3	4.8	141.9	87.9	12.1
	Miami, FL PMSA	L	69.7	20.1	0.2	1.4	57.3	1,532	5.8	6.0	432.0	99.3	0.7
	New Orleans, LA	L	57.3	37.4	0.4	2.1	4.4	918	7.1	4.9	148.2	93.5	6.5
	Washington, DC-MD-VA-WV PMSA	L	60.0	25.9	0.3	6.7	8.7	537	2.3	3.4	281.1	90.4	9.6
Midwest	Chicago, IL PMSA	X	65.8	18.8	0.2	4.7	17.1	NA	3.9	4.7	610.5	98.1	1.9
	Detroit, MI PMSA	L	71.2	22.8	0.4	2.3	2.9	870	4.0	4.4	433.3	93.6	6.4
	Sioux Falls, SD	S	93.5	1.3	1.8	1.0	1.9	252	2.3	2.4	45.8	87.9	12.1
	St. Louis, MO	L	78.3	18.2	0.3	1.4	1.5	NA	3.7	4.2	155.2	78.3	21.7
West	Billings, MT	S	93.0	0.4	3.1	0.6	3.7	187	3.9	3.5	18.6	83.3	16.7
	Denver, CO PMSA	L	79.3	5.4	0.9	3.0	18.8	385	2.6	3.2	203.2	96.0	4.0
	Honolulu, HI	M	21.2	2.2	0.2	55.0	6.7	268	3.1	4.3	556.4	98.4	1.6
	Los Angeles-Long Beach, CA PMSA	X	48.6	9.6	0.7	12.2	44.6	1,027	6.8	5.9	887.3	99.3	0.7
	Seattle-Bellevue-Everett, WA PMSA	L	78.4	4.3	1.0	9.8	5.2	419	2.2	3.6	203.7	93.1	6.9

*Small = <300,000 persons; Medium = 300,000–1 million persons; Large = 1 million–5 million persons; Extra Large = >5 million persons

[a] Source: 2000 U.S. Census, 2000 data

[b] Source: 2001 County and City Extra: Annual Metro, City, and County Data Book, Tenth Edition. Eds: Gaquin, D.A., and Littman, M.S. Washington, DC: Bernan Press, 1998 data

[c] Source: 2001 County and City Extra: Annual Metro, City, and County Data Book, Tenth Edition. Eds: Gaquin, D.A., and Littman, M.S. Washington, DC: Bernan Press, 1999 data

APPENDIX 3: NATIONAL-LEVEL DATA SOURCES AVAILABLE IN THE 20 PULSE CHECK SITES

	Pulse Check Site	HIDTA[1] State	CEWG[2]	DAWN[3]	ADAM[4]
Northeast	Boston, MA	✓	✓	✓	
	New York, NY	✓	✓	✓	✓
	Philadelphia, PA	✓	✓	✓	✓
	Portland, ME	✓			
South	Baltimore, MD	✓	✓	✓	
	Columbia, SC				
	El Paso, TX	✓	✓		
	Memphis, TN	✓			
	Miami, FL	✓	✓	✓	✓
	New Orleans, LA	✓	✓	✓	✓
	Washington, DC	✓	✓	✓	✓
Midwest	Chicago, IL	✓	✓	✓	✓
	Detroit, MI	✓	✓	✓	✓
	Sioux Falls, SD	✓			
	St. Louis, MO	✓	✓	✓	
West	Billings, MT				
	Denver, CO	✓	✓	✓	✓
	Los Angeles, CA	✓	✓	✓	✓
	Honolulu, HI	✓	✓		✓
	Seattle, WA	✓	✓	✓	✓

[1] *High Intensity Drug Trafficking Area of the Drug Enforcement Administration (DEA)*

[2] *Community Epidemiology Work Group of the National Institute on Drug Abuse (NIDA)*

[3] *Drug Abuse Warning Network of the Substance Abuse and Mental Health Services Administration (SAMHSA)*

[4] *Arrestee Drug Abuse Monitoring program of the National Institute of Justice (NIJ)*

Note: Shaded boxes indicate that selected citiy is in a rural State.

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APPENDIX 4: PULSE CHECK SOURCES

Pulse Check Site	Epidemiology/Ethnography	Law Enforcement
Baltimore, MD	**James Peterson** Johns Hopkins University School of Public Health	**Robert J. Penland** Washington-Baltimore HIDTA
Billings, MT	**Ernesto Randolfi, Ph.D.** Montana State University at Billings Department of Health and Physical Education and Human Services	**Scott Forshee** City/County Special Investigations Unit
Boston, MA	**George Arlos** Organization prefers anonymity	**Lieutenant Francis W. Armstrong, Jr.** Boston Police Department Drug Control Division
Chicago, IL	**Larry Ouellet, Ph.D.** EPI/BIO COIP School of Public Health	**Individual prefers anonymity** Chicago Police Department Organized Crime Division, Narcotic and Gang Investigations Section
Columbia, SC	**Individual prefers anonymity** Department of Alcohol and Other Drug Abuse Services	**C.O. Clark** Columbia Police Department Organized Crime and Narcotics Unit
Denver, CO	**Bruce D. Mendelson, M.P.A.** State Treatment Needs Assessment Contract Colorado Department of Human Services Alcohol and Drug Abuse Division	**Curt Williams and Rob McGregor** Denver Police Department Fugitive Location and Apprehension Group
Detroit, MI	**Richard F. Calkins** Michigan Department of Community Health Division of Quality Management and Planning	**Individual prefers anonymity** Southeast Michigan HIDTA
El Paso, TX	**Tessa Hill, M.A.** Aliviane, Inc.	**Jeff Cole** Organization prefers anonymity
Honolulu, HI	**D. William Wood, Ph.D., M.P.H.** University of Hawaii Department of Sociology	**Lieutenant Mike Moses** Honolulu Police Department Narcotics, Vice Division
Los Angeles, CA	**Beth Finnerty, M.P.H.** University of California, Los Angeles Integrated Substance Abuse Programs (ISAP)	**Eric Lillo** Los Angeles Police Department
Memphis, TN	**Randolph Dupont, Ph.D.** Department of Psychiatry University of Tennessee	**Fred Romero** Memphis Police Department Vice Narcotics Unit
Miami, FL	**James N. Hall** Up Front Drug Information Center	**Prefers anonymity**
New Orleans, LA	**Gail Thornton-Collins** New Orleans Health Department	**Lieutenant Reginald Jacque** New Orleans Police Department Narcotics Major Case Section
New York, NY	**John A. Galea, M.A.** New York State Office of Alcoholism and Substance Abuse Services Street Studies Unit	**Individual prefers anonymity** Drug Enforcement Administration New York Division Unified Intelligence (S-13)
Philadelphia, PA	**Samuel J. Cutler** Philadelphia Behavioral Health System Coordinating Office for Drug and Alcohol Abuse Programs	**Ken Bergmann** Organization prefers anonymity
Portland, ME	**Nate Nickerson, R.N., M.S.N.** Public Health Division, Department of Health and Human Services City of Portland	**George Connick** Maine Drug Enforcement Administration
Seattle, WA	**Thomas R. Jackson, M.S.W.** Evergreen Treatment Services	**Steve Freng** High Intensity Drug Trafficking Area
Sioux Falls, SD	**Darcy Jensen** Prairie View Prevention Services	**Jerry Mundt** Sioux Falls Police Department Narcotics Division
St. Louis, MO	**James M. Topolski, Ph.D.** Missouri Institute of Mental Health	**Detective Leo Rice** St. Louis Police Department Narcotics Division
Washington, DC	**Jerry Brown** Department of Health HIV/AIDS Administration	**Sergeant John Brennan** Washington, D.C. Police Department Major Narcotics

APPENDIX 4: PULSE CHECK SOURCES

Pulse Check Site	Non-Methadone Treatment	Methadone Treatment
Baltimore, MD	**Adrienne Britton-Robinson, BA, CAC** Total Health Care	**Cindy Shaw** Institute for Behavior Resources (IBR Reach)
Billings , MT	**Mona Sumner** Rimrock Foundation **Rhonda Stennerson** South Central Mental Health Center Journey Recovery Program	**(Illegal in the State of Montana)**
Boston, MA	**Jim Sweeney** Gavin House	**Lawrence O'Toole** Habit Management
Chicago, IL	**Nick Gantes** Gateway Foundation	**Individual prefers anonymity** Cornell Interventions
Columbia, SD	**Laura Truesdale** Palmetta Baptist Medical Center Outpatient Behavioral Health Services	**Jim Van Frank** Columbia Metro Treatment Center
Denver, CO	**Tim McCarthy** Arapahoe House	**Pamela J. Manuele, RN, BSN, ANPC, CCJS** Comprehensive Addiction Treatment Services
Detroit, MI	**Peter Mason** Renaissance West Community Health Services	**Octavius Sapp, C.A.C.** City of Detroit, Department of Human Services Drug Treatment Program
El Paso, TX	**Armando Salas** Aliviane Men's Residential Facility	**Julie Renteria, L.V.N.** El Paso Methadone Maintenance and Detox Treatment Center
Honolulu, HI	**Prefers anonymity**	**Lorianne Bean** **Lisa Cook** **Marcia Tsuehoriuchi** Drug Addiction Services of Hawaii
Los Angeles, CA	**Mari Radzik, Ph.D.** Substance Abuse Treatment Program Division of Adolescent Medicine Children's Hospital of Los Angeles	**Individual prefers anonymity** Aegis Medical System
Memphis, TN	**Bonnie Moody, LCSW** Community Behavioral Health Center	**Rusty Titsworth** Memphis Center for Research and Addiction Treatment
Miami, FL	**Michael Miller, Ph.D.** The Village South, Inc. Addiction Treatment Center	**Prefers anonymity**
New Orleans, LA	**Eleanor Glapion** New Orleans Substance Abuse Clinic	**Nonrespondent**
New York, NY	**Prefers anonymity**	**Individual prefers anonymity** Lower Eastside Service Center
Philadelphia, PA	**Chris Sweeney** Northeast Treatment	**Prefers anonymity**
Portland, ME	**Stephen Leary** Milestone Foundation, Inc.	**Marty O'Brien** Discovery House Maine
Seattle, WA	**Ramona Graham** Center for Human Services	**Victoria Evans** Therapeutic Health Services
Sioux Falls, SD	**Nicole McMillin** Volunteers of America Dakotas **Nonrespondent**	**(Illegal in the State on South Dakota)**
St. Louis, Missouri	**Mike Morrison** Bridgeway Counseling	**Cheryl Gardine** DART
Washington, D.C.	**James Shepard** Organization prefers anonymity	**LaTonya Sullivan** Organization prefers anonymity

APPENDIX 5: DISCUSSION AREAS BY SOURCE TYPE*

Topic	L	E	M	N
SPECIAL SECTION: A LOOK AT LOCAL DRUG MARKETS				
How difficult is it for users/undercover police to buy specific drugs?**	✓	✓		
During this reporting period, has there been a time when users could not buy specific drugs? If yes, when and why?	✓	✓		
Is there any particular day, week, or month that local drug markets seem more active? If yes, when? To what do you attribute this phenomenon?	✓	✓		
Where do users buy their drugs most of the time?	✓	✓		
Which specific neighborhood(s) in your city has the greatest concentration of drug sales?	✓	✓		
What else, besides cash, do users trade or exchange for drugs?	✓			
What else, besides cash, do dealers accept in exchange for drugs?		✓		
What has, in the past, deterred street buys of any particular drug? In your opinion, what would, in the future, deter such buys?	✓	✓		
List and describe any recent targeted law enforcement or legislative policy directives or initiatives. How did it impact on your community's overall drug abuse problem, either for better or worse?	✓	✓		
What gaps or challenges, if any, do you perceive in your community's current law enforcement efforts?		✓		
What are any recent developments or trends in your State, in areas beyond your city, that could eventually affect your city's drug abuse problem—either for better or worse—in the future?	✓	✓		
How do street-level drug dealers communicate with their fellow street dealers? With their suppliers? With their buyers?	✓			
How do dealers transport drugs to their selling locations?	✓			
To the best of your knowledge, what happens to the cash collected by street-level dealers?	✓			
Do you have any suggestions for ways to disrupt local drug market activity?	✓			
THE SNAPSHOT				
How serious is the current illegal drug problem in your community?	✓	✓	✓	✓
How has the illegal drug problem changed in your community?	✓	✓	✓	✓
THE PERCEPTION				
During the current and last reporting periods, what was the most widely abused drug in your community? Second most widely abused drug? What drug was related to the most serious consequences? Second most serious consequences? Is any new problem drug appearing in your community?	✓	✓	✓	✓
THE DRUG**				
How available is the drug in your community (for each drug, asks about various forms)?	✓	✓		
How has availability changed?	✓	✓		
What are the most common and second most common units of sale and corresponding standard units of the drug?	✓	✓		
What is the purity range for the drug during the current reporting period? During the last reporting period?	✓	✓		
What is the price range during the current reporting period? During the last reporting period?	✓	✓		
Are there any adulterants? If yes, please list and indicate if any are new this reporting period.	✓	✓	✓	✓
Why have price, purity, or adulterants changed or why have they remained stable?	✓	✓		
What is the source for your price, purity, and adulterant information?	✓	✓		
What are the street names, and are any of these new this reporting period?	✓	✓	✓	✓
What types of packaging are used, and are any of these new this reporting period?	✓	✓		
Are labels or brand names used? If yes, please list and indicate if any are new this reporting period.	✓	✓		
Have street names, packaging, or label/brand names changed since the last reporting period?	✓	✓		
How is the drug locally manufactured, processed, or grown?	✓	✓		
Have there been any changes in the local manufacturing process since the last reporting period?If yes, please describe.	✓	✓		
THE SALE**				
What is the predominant affiliation of local, street-level sellers?	✓	✓		
What is the predominant age range of local, street-level sellers?	✓	✓		
How likely are sellers to use their own drugs?	✓	✓		
In what types of other crimes are sellers involved?	✓	✓		
Have there been any changes in seller characteristics since the last reporting period? If yes, please describe.	✓	✓		
Are there any new sellers groups this reporting period? If yes, please describe.	✓	✓		
What is the geographical area where most street-level sales of the drug occur?	✓	✓		
Is the drug sold mostly indoors, outdoors, or evenly split between both?	✓	✓		
In what settings is the drug sold?	✓	✓		
How is the drug sold?	✓	✓		

THE SALE** (continued)	L	E	M	N
Are other drugs sold by this type of dealer? If yes, please list the drugs.	✓	✓		
Have any of the drugs sold with this drug changed since the last reporting period? If yes, please describe.	✓	✓		
Have any of the drug scene characteristics changed since the last reporting period? If yes, please describe.	✓	✓		
THE USERS: Predominant characteristics**				
How did the number of users chnage since the last reporting period?	✓			
What is total numbe of primary users (of each drug) in your program? Total number of users (primary+secondary+tertiary) of each drug? How did these numbers change since the last reporting peroid?			✓	✓
What is the predominant age range of the drug users, and has it changed since the last reporting period?		✓	✓	✓
What is the predominant gender, and has it changed since the last reporting period?		✓	✓	✓
What is the predominant racial/ethnic group, and has it changed since the last reporting period? Is this group underrepresented, overrepresented, or about equal compared with the general population in your area?		✓	✓	✓
What is the predominant socioeconomic position, and has it changed since the last reporting period?		✓	✓	✓
What is the most common geographical residence, and has it changed since the last reporting period?		✓	✓	✓
What is the predominant route of administration, and has it changed since the last reporting period?		✓	✓	✓
What are the drugs commonly taken with this drug? Are they taken sequentially, in combination with, or as a substitute for for the drug? What are the street names for this combination or practice?		✓	✓	✓
Is the drug used mostly in public or in private?		✓	✓	✓
Is the drug used mostly alone or in groups/among friends?		✓	✓	✓
What are the common settings for the use of this drug?		✓	✓	✓
What is the most common referral source, and has it changed since the last reporting period?			✓	✓
What is the predominant education level, and has it changed since the last reporting period?			✓	✓
What is the most common frequency of use, and has it changed since the last reporting period?			✓	✓
What is the predominant employment status, and has it changed since the last reporting period?			✓	✓
What are the adverse consequences of marijuana abuse, and have they changed since the last reporting period?		✓	✓	✓
THE USERS: New/emerging users**				
How did the number of new or emerging users change since the last reporting period? If increased, repeat the first 10 questions under "the users: predominant characteristics" for the new/emerging user group.		✓		
Among all clients in your program, and among first-time admissions, what is the total number of primary users (of each drug)? Total number of users (primary+secondary+tertiary) of each drug? How did these numbers change since the last reporting period? For the first-time admission group, if increased, repeat all questions under "the users: predominant characteristics."			✓	✓
METHADONE DIVERSION/TREATMENT				
What is the availability of methadone treatment in your community?		✓		
How has treatment availability changed since the last reporting period?		✓		
What is the capacity of public methadone treatment? Private methadone treatment?		✓		
How has the capacity of public methadone treatment changed since the last reporting period? Private methadone treatment?		✓		
COMMUNITY CONTEXTS				
Have drug-related consequences (HIV/AIDS, hepatitis C, liver cirrhosis, drug-related automobile accidents, high-risk pregnancy, drug overdoses, alcohol DTs, tuberculosis, other) increased, decreased, or remained stable since the last reporting period? If changed, explain.			✓	✓
Have any psychatric commorbidity diagnoses increased or decreased as a concern among your clients since the last reporting period?			✓	✓
Do any potential barriers (limited slot capacity, lack of trained staff to treat comorbid clients, violent behavior among presenting clients, age restrictions, other) prevent your program from serving all individuals who seek treatment? If yes, explain.			✓	✓
TREATMENT BACKGROUND				
What is your program's maximum capacity?			✓	✓
What is your current enrollment?			✓	✓
Does your program's clientele reflect the population of your local community? If no, please describe.			✓	✓

[L] *Law enforcement*

[E] *Epidemiologic/ethnographic*

[M] *Methadone treatment*

[N] *Non-methadone treatment*

**Please note that for the methadone and non-methadone treatment interviews, "community" was replaced with "program."*

***Respondents were asked about heroin, crack, powder cocaine, methamphetamine, marijuana, ecstasy, OxyContin®, and any other drugs (specify) for each of the discussion areas.*

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